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ABSTRACT

The conference focused on the role of the Mexican American's cultural language, tradition, life style, health practices, and media utilization in the design of effective health education and information programs. Representing various local, state, and national health, education, and media organizations, the 108 participants attended sessions on sociocultural factors, health values, and perceptions affecting health communication, and use and evaluation of media in disseminating health information. Each session consisted of a keynote address, three or four related research presentations, and a workshop session. Workshop participants used a health communications methodology to complete a case study which involved the design of a model health communications campaign to educate the Mexican American community about services provided by a health maintenance organization for cardiovascular disease. A media critique session provided participants with guidelines for content and production which should be considered in designing health communication materials. Topics of the research presentations included the determination of Hispanic knowledge, attitudes and practices related to cancer for the purpose of education programs; alternative methods of presenting bilingual health education messages; and a videotape package to reach Hispanics with cancer health education. This report contains the keynote and research presentations, workshop results, conference evaluation and evaluation questionnaire, media critique forms, and the case study. (NQA)

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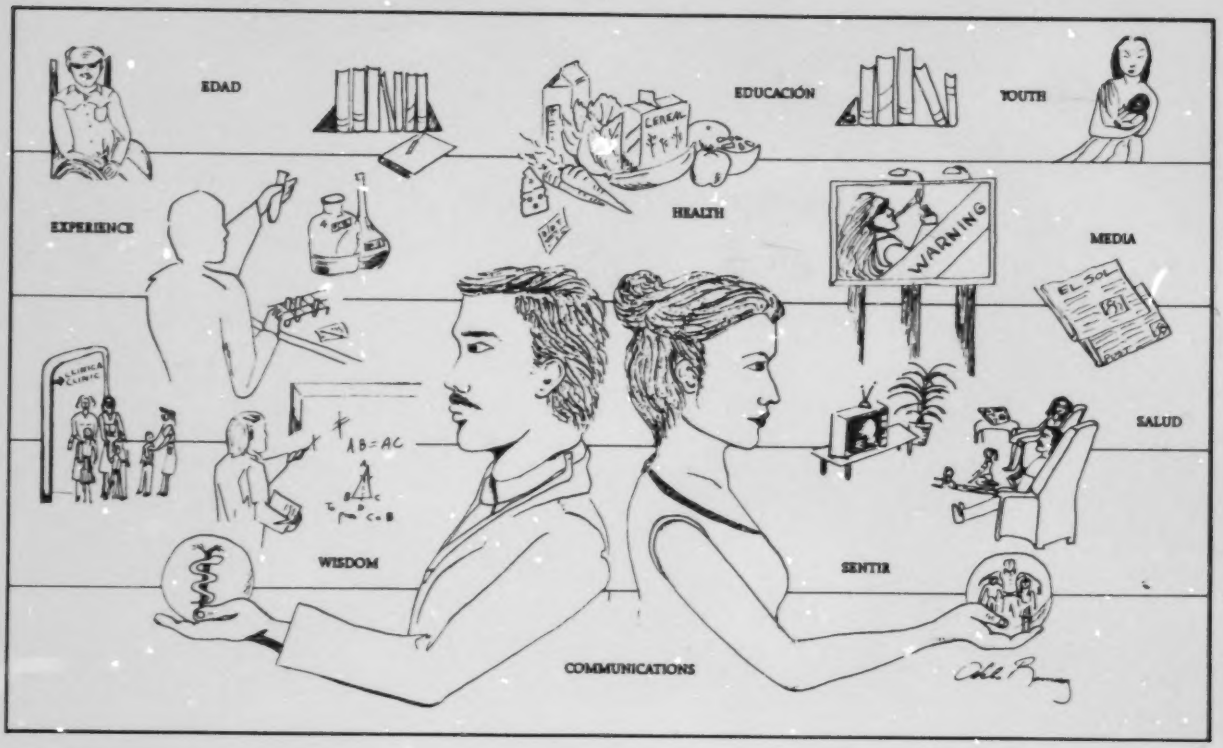

PROCEEDINGS OF
THE CONFERENCE ON

Communicating With Mexican Americans: Por Su Buena Salud

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U.S. Department of Health And Human Services,
Public Health Service, National Institutes Of Health

The cover illustration (September 1979) vignettes the vast array of media reaching the Mexican American communities. The artist, Adela Ramirez, is from the High School for the Performing and Visual Arts in Houston, Texas.

PROCEEDINGS OF THE CONFERENCE ON

COMMUNICATING WITH MEXICAN AMERICANS: POR SU BUENA SALUD

COMUNICANDO CON MÉXICO AMERICANOS: FOR THEIR GOOD HEALTH

September 13 and 14, 1979

Houston, Texas

Sponsored by

Baylor College of Medicine
National Heart and Blood Vessel Research and Demonstration Center
Communications Core

National High Blood Pressure Education Program
and
National Heart, Lung and Blood Institute,
National Institutes of Health

Chairperson: Amelie G. Ramirez
Cochairperson: Frank J. Weaver

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PREFACE

Research information available on the health status and behaviors of Mexican Americans is very limited.[1-4] Few published studies exist which describe their unique medical care practices, health knowledge and values, or the effectiveness of health communication strategies in reaching this growing population. Information in these areas is essential to health educators and health care providers because it supplies the basis for a better understanding of how to improve health communications with Mexican Americans to help them achieve a high level of wellness.

Since its inception, the communications core of the National Heart and Blood Vessel Research and Demonstration Center (NRDC) at Baylor College of Medicine has been concerned with the development and evaluation of communications strategies to disseminate needed preventive health information on cardiovascular disease to selected audiences. The NRDC was established in 1975 by the National Heart and Lung Institute, now the National Heart, Lung and Blood Institute (NHLBI), and National Institutes of Health (NIH) to integrate basic and clinical research with education and community demonstration programs to mount a comprehensive multidisciplinary attack against cardiovascular disease.

To design communications programs based on known rather than assumed audience needs and characteristics, the communications core conducted a community survey of residents 18 years and older in Harris County, Texas. The survey determined the respondents' knowledge, attitudes, and practices related to cardiovascular disease and its associated risk factors, as well as their media habits. Survey results showed the Mexican American population was less knowledgeable about cardiovascular disease and had different media habits than the Anglo population. Based on these findings, one of the programs the core developed was a television public service hypertension information campaign to reach the Houston Mexican American community. Three television public service announcements (PSA's) were produced in Spanish and aired for 6 weeks.

The results of the communications core's survey and the evaluation of the hypertension campaign combined with the interest of NHLBI, the National High Blood Pressure Education Program (NHBPEP), and others in communicating needed health information to Mexican Americans led to the development of the Conference on Communicating with Mexican Americans: Por Su Buena Salud (Comunicando con México Americanos: For Their Good Health). The conference focused on the role of the Mexican American's cultural language, tradition, lifestyle, health practices, and media utilization in the design of effective health education/information programs. Invitees included selected individuals from various local, state and national health, educational and media organiza-

tions who deliver health care, disseminate health information to Mexican Americans, or conduct related research.

Abstracts were solicited for presentations in the conference's three major areas: 1) sociocultural factors which affect communications about health; 2) health values and perceptions which affect health communications; and 3) use and evaluation of media in the dissemination of health information. Each area consisted of a keynote address and related research presentations and group workshop sessions. In the workshop sesions, participants used a health communications methodology designed by the communications core to complete a case study assignment. The methodology provides a framework for the planning, development, and evaluation of health information programs and materials. The case study assignment was to design a model health communications campaign to inform the Mexican American community about the existence of and services provided by a health maintenance organization for cardiovascular disease.

A media critique session was also held to provide attendees with guidelines for designing content and producing health communication materials. Participants used standardized media critique forms to objectively evaluate the effectiveness of print and audiovisual health information and promotion materials produced by three Houston organizations.

Two evaluation phases were conducted to determine the participants' initial and followup assessment of the conference. In general, most participants were quite pleased with the conference and desired more conferences on this topic in the future.

We are grateful to the National High Blood Pressure Education Program and the National Heart, Lung, and Blood Institute, National Institutes of Health for their cosponsorship of and contributions to the Conference on Communicating with Mexican Americans: Por Su Buena Salud. The guidance of Robert I. Levy, M.D., director of NHLBI, NIH; Annie Collins, coordinator of community development, NHLBI, NIH; and Clifford Richmond, minority specialist with NHBPEP, and their compassion for the health needs of the Mexican American community provided us with the inspiration and confidence needed to make the conference a reality.

We would also like to express our appreciation to all those at Baylor College of Medicine's National Heart and Blood Vessel Research and Demonstration Center who supported our efforts to sponsor the conference and whose guidance and assistance were instrumental to its success. These people include: Michael E. DeBakey, M.D., director; Antonio M. Gotto, Jr., M.D., scientific director; Carlos Vallbona, M.D., chief, control and demonstration division; E. J. Farge, Ph.D., consultant, communications core; Judith A. Kautz, Ph.D., biostatistician, design and analysis core; and the staff of the communications core, William R. Gombeski, Jr., Thomas J. Moore, Ruth Schlanger, and

Patricia L. Slayton, for their dedicated efforts in making the conference run so smoothly and preparing the conference proceedings.

Finally, we would like to thank the many individuals from the academic, communications, and health communities who shared our desire to provide a forum for the exchange of information on research and experience in the communication of health information to the Mexican American community. Without their support, this conference would not have been possible.

Amelie G. Ramirez
Conference Chairperson

Frank J. Weaver
Conference Cochairperson

FOOTNOTES

1. Farge, Emile J. La Vida Chicana: Health Care Attitudes and Behaviors of Houston Chicanos. California: Rand E. Research Associates, 1975.
2. Glenn, Norval. "Some Reflections of a Landmark Publication and the Literature on Mexican Americans." Social Science Quarterly, Vol. 50, No. 2, 1973.
3. The Nation's Health. "The Lack of Data on the Health Status of the Spanish Heritage Community in the United States." December 1977, APHA, Washington, D.C.
4. Weaver, Jerry. "Mexican American Health Care Behavior: A Critical Review of the Literature." Social Science Quarterly, Vol. 54, No. 1, 1973.

COMMUNICATING WITH MEXICAN AMERICANS: POR SU BUENA SALUD

COMUNICANDO CON MÉXICO AMERICANOS: FOR THEIR GOOD HEALTH

September 13 and 14, 1979

Houston, Texas

AGENDA

THURSDAY, SEPTEMBER 13, 1979
MORNING SESSION:

8:00 a.m. RECORDERS' MEETING

8:30 a.m. REGISTRATION

9:00 a.m. WELCOME

Amelie Gutierrez Ramirez, MPH, Conference Chairperson
Frank J. Weaver, Conference Cochairperson
Baylor College of Medicine
National Heart and Blood Vessel
Research and Demonstration Center
Houston, Texas
Clifford Richmond
National High Blood Pressure Education Program,
National Heart, Lung and Blood Institute
National Institutes of Health
Washington, D.C.

9:10 a.m. SOCIOCULTURAL FACTORS AFFECTING COMMUNICATIONS ABOUT HEALTH
Leonel J. Castillo
Immigration and Naturalization Service
Washington, D.C.

9:30 a.m. RESEARCH PRESENTATIONS

DETERMINATION OF HISPANIC KNOWLEDGE, ATTITUDES AND PRACTICES RELATED TO CANCER FOR THE PURPOSE OF EDUCATIONAL PROGRAMS
Robert W. Denniston
Rose Mary Romano
National Cancer Institute
Bethesda, Maryland

9:45 a.m. COMMUNICATING WITH MEXICAN AMERICANS BY WORKING WITH AND THROUGH PROVIDERS
Daniel E. Costello, Ph.D.
Vanderbilt University Medical Center
Nashville, Tennessee

10:00 a.m. A REVIEW OF AN ORIENTATION PROGRAM FOR PHYSICIANS ENTERING MEDICAL PRACTICE IN A MEXICAN AMERICAN COMMUNITY
Dennis J. Mull, MD
University of California
Irvine Medical Center
Orange, California

10:15 a.m. ¿CÓMO TE SIENTES? - PREVENTING CHILDHOOD HEALTH PROBLEMS
Doris B. Key, MA
Francisco R. Perez, Ph.D.
Department of Foreign Languages
Texas Woman's University
Denton, Texas

10:30 a.m. COFFEE BREAK

10:45 a.m. WORKSHOP SESSION I - IDENTIFYING THE PROBLEM

AFTERNOON SESSION:

12:30 p.m. LUNCHEON

HEALTH VALUES AND PERCEPTIONS AFFECTING COMMUNICATIONS
Juan Antonio Chavira, Ph.D.
University of Texas
Health Science Center
San Antonio, Texas

1:30 p.m. RESEARCH PRESENTATIONS

A STUDY OF ALTERNATIVE METHODS OF PRESENTING BILINGUAL HEALTH EDUCATION MESSAGES
David W. Martin, Ph.D.
School of Public Health
University of Texas
Health Science Center at Houston
Gale E. Morrow, MPH
Health Educator
Project Concern
Pando, Bolivia

1:45 p.m. ANTIHYPERTENSIVE STUDY IN A PREDOMINANTLY MEXICAN AMERICAN POPULATION
Ramon R. Robles
El Rio Santa Cruz Neighborhood Health Center Inc.
Tucson, Arizona

2:00 p.m. ESPERANZA: A VIDEOTAPE PACKAGE TO REACH HISPANICS WITH CANCER HEALTH EDUCATION

Judith L. Rogers
New Mexico Cancer Control Program
Frank G. Schultz
New Mexico Health Coalition
Albuquerque, New Mexico

2:15 p.m. RETURN OF THE MEDICINE SHOW
Joseph J. Simoni, Ph.D.
West Virginia University
Morgantown, West Virginia
Luis Alberto Vargas, MD, Ph.D.
Leticia E. Casillas, MD
Instituto De Investigaciones Antropologicas
Ciudad Universitaria
Mexico City, Mexico

2:30 p.m. COFFEE BREAK

2:45 p.m. WORKSHOP SESSION II - HEALTH OPERATIONS

5:00 p.m. ADJOURNMENT

6:00 p.m. COCKTAIL RECEPTION

FRIDAY, SEPTEMBER 14, 1979
MORNING SESSION:

8:00 a.m. MEDIA CRITIQUE

Review and evaluate mass and special media designed for the Hispanic Community: TV, Radio, Print Material

POSTER PRESENTATION: SOURCES OF HEALTH INFORMATION
Thomas J. Moore, MS
William R. Gombeski, Jr., MPH
Baylor College of Medicine
National Heart and Blood Vessel
Research and Demonstration Center
Houston, Texas

9:00 a.m. USE AND EVALUATION OF MEDIA IN DISSEMINATING HEALTH INFORMATION
Felix F. Gutierrez, Ph.D.
School of Journalism
University of Southern California
Los Angeles, California

9:30 a.m. RESEARCH PRESENTATIONS

MAJOR MEDIA CONSUMPTION HABITS OF MEXICAN AMERICANS IN SAN ANTONIO
Robert S. Franz, Ph.D.
University of Southwestern Louisiana
Lafayette, Louisiana

Charles N. Weaver, Ph.D.
St. Mary's University
San Antonio, Texas
Colonel John A. Geurin
United States Air Force
San Antonio, Texas

9:45 a.m. TELEVISION MESSAGES VERSUS HEALTH COMMUNICATION
Hector Velez Guadalupe, MA
Eisenhower College of Rochester
Institute of Technology
Seneca Falls, New York

10:00 a.m. COFFEE BREAK

10:15 a.m. WORKSHOP SESSION III - SELECTING COMMUNICATION CHANNELS

12:30 p.m. LUNCHEON

REMARKS
Antonio M. Gotto, Jr., MD
Scientific Director
National Heart and Blood Vessel
Research and Demonstration Center
Baylor College of Medicine
Houston, Texas
Mario E. Ramirez, MD
President
Texas Medical Association
Rio Grande City, Texas

2:00 p.m. GROUP PRESENTATIONS OF MODEL PROGRAMS

3:00 p.m. RECOMMENDATIONS

3:15 p.m. CLOSING REMARKS
Annie R. Collins
Health Education Branch
National Heart, Lung and Blood Institute
National Institutes of Health
Bethesda, Maryland

THANK YOU
Amelie Gutierrez Ramirez
Conference Chairperson

Frank J. Weaver
Conference Cochairperson

SESSION I:

Sociocultural Factors Affecting Communications About Health

SESSION I: SOCIOCULTURAL FACTORS AFFECTING COMMUNICATIONS ABOUT HEALTH

KEYNOTE ADDRESS: LEONEL J. CASTILLO

Leonel J. Castillo, former Commissioner, Immigration and Naturalization Service of the Department of Justice, Washington, D.C., is noted for his concern for the Mexican American community and played a major role in strengthening United States relations with Mexico. Prior to his present position, Commissioner Castillo was actively involved in community programs aimed at improving health care services and job opportunitites for disadvantaged persons.

Thank you for asking me to be with you today at the Conference on Communicating with Mexican Americans: Por Su Buena Salud. I am glad to be here and want to preface my remarks with a quote from A Nation of Immigrants by John F. Kennedy: "The contributions of immigrants can be seen in every aspect of our national life. We see it in religion, in politics, in business, in the arts, in education, even in athletics and in entertainment."

Every immigrant group has made contributions to our Nation in a variety of fields and it is apparent that immigrants have had and continue to have a direct impact on our country's health care system. Take, for example, Dr. Carlos Vallbona, chairman of community medicine here at Baylor, who has made substantial contributions to the medical field in the areas of rehabilitative medicine, primary care, and medical education. Currently, however, there are issues which have to be addressed by the medical profession in terms of health care for any ethnic group, namely, the facilitation and delivery of services, disease prevention, and to educate and communicate with the masses in this country about health care.

Every ethnic group immigrating to this country has brought with it a series of social and cultural attitudes toward illness, health and medical care. Some of these attitudes are derived from a particular group's "folk" concepts and/or beliefs.

For instance, in the Asian community, Chinese medicine teaches that health is a state of spiritual and physical harmony with nature, and illness is seen as the lack of harmony of the body with the universe. By contrast, in the Hispanic community, some sources state that health is defined as the result of good luck; others believe that it is a reward for good behavior--a reward from God. It thus represents a state of equilibrium within the universe.

The Hispanic community is composed of various ethnic groups. However, I would like to address the sociocultural heritage and its relationship to the health care needs of a member group, namely, the Mexican American.

Immigration and Naturalization Service statistical records for 1977 show that of the 462,315 immigrants admitted to this country, 44,079 were from the country of Mexico. Generally, most of these individuals enter to join with immediate relatives who are United States citizens. The majority initially settle in "colonias" (colonies) or "barrios" (neighborhoods) where language and most cultural traditions are maintained.

Socioeconomic class structure and educational level will determine the mobility, adaptability and settlement patterns of this group in the Anglo society. Generally, resettlement of Mexican Americans has occurred in the southwestern part of the United States. The phenomenon is due primarily to the proximity to the "homeland," which could be viewed as a reduction factor to cultural adjustment, but a negative factor to acculturation.

What happens, however, to those individuals who remain in the ethnic communities when medical attention is required? What sociocultural interactions occur between the provider and the receiver of health services?

First, what has been referred to in several literary works on health care as the "subculture thesis" comes into play; that is, patients treat themselves, are treated by family friends, or visit a "curandero" (natural healer/lay practitioner).

"Curanderismo," which has its roots in a mixture of Aztec and Spanish spiritualistic, hemeopathic, and scientific elements, continues to be an integral part of the lives of second and third generation Mexican Americans. The neighborhoods usually have a "curandero" or a series of lay practitioners who are residents of the area. And there is always a local "botica" (pharmacy) which carries the vast array of medications, preparations, and religious items.

The "curandero" can be referred to as an individual who, through practical experience and not theory, has acquired the skill or has the natural ability to heal. Generally, there are religious, spiritualistic and/or counseling overtones associated with the treatment and/or prescription. Most importantly, the "curandero" does not require a fee.

There are other healers, such as the "yerbero" (herbalist) who is considered to have expertise in the use of herbs and spices to cure or prevent an illness. The "sobador" is a specialist in massage treatment and muscle and bone manipulation. The "partera" (midwife), who is always a woman, continues to influence the attitudes of the Mexican American woman. Generally, the contention among Mexican American women is that the reproductive process is a private matter between women. Then there is the "espiritualista," who has the capacity to interpret dreams and make projections into the future. The "brojo(a)" (witch) has control over the malevolent and benevolent techniques of

witchcraft. This person has the facility and capability to cast either a good or a bad spell, and he/she can also break a spell. In addition, people who come to this country from Mexico are basically people of great faith. This is primarily due to the dominant role which the Catholic church had and continues to have, although more subdued, in that country. This great faith is passed on to descendents. "Curanderos" in some instances can be referred to as "faith healers." Therefore, magico-religious practices are common. The more severe the illness, the more likely the practices of: 1) "promesas," the making of promises to a saint; 2) the visiting of shrines; 3) the offering of medals and candles; and 4) the offering of prayers, are observed.

There are a number of folk diseases that are treated with herbs, massage, and/or the restoration of the body's balance. For example, a folk disease such as "pasmo," a form of paralysis that is caused by a "hot-cold" imbalance, is treated by the restoration of the balance and by massage. Herbs such as garlic for fever, toothaches, and anorexia; "manzanilla" (chamomile) for stomach and intestinal pain, and linseed for constipation are readily available and utilized.

Why are these practices so much a part of the life of a Mexican American? The simplest way to respond to this question is, "the lines of communication and understanding are present."

To the Mexican American, the lay practitioner is generally symbolic of social and cultural ties. This means that common elements such as language, education, religion, and economic standards are generally comparable. The provider/recipient relationship is easily established, which, of course, facilitates the delivery of services. Furthermore, "curanderos" are local neighborhood residents, therefore eliminating transportation costs. A visit to a "curandero" in some instances is considered a social occasion. There are little to no cultural barriers to overcome.

Nowadays you can identify more cases where a Mexican American will visit a lay practitioner and physician simultaneously. When this happens, you confront several social and cultural issues. The patient is now faced with the enigma of who is more capable in terms of providing the therapy, treatment and/or medication which will cure the illness.

There are minimal problems in the provider/recipient relationship with the traditional health care approach which continues to be the primary care for many Mexican Americans. Many, however, will not admit to the traditional approach simply because it causes embarrassment.

By contrast, there are problems in relating to the medical professional. The current methodologies employed by the medical profession are foreign to the recipient, only adding to his/her anxiety. Admittance

of the traditional approach to health care could result in a reprimand by the medical professional. Language continues to be a barrier--the medical profession needs more Spanish-speaking physicians, nurses and aides.

There is a need for medical personnel to explain a problem and the treatment recommended to a patient, not only in his/her own language, but in terms the person can understand and relate to. Improvement in this area can only improve the delivery of health services.

Over half of the total Mexican American population in the United States is at the poverty level or below, despite state and government health and public assistance programs. Individuals are concerned about meeting their living expenses, and health is only a secondary consideration. Furthermore, professional medical counseling and/or treatment is expensive. Then there are transportation costs to be incurred. Since the family unit is strong, the patient will not go unaccompanied, particularly if he/she is to visit a medical professional. Hospitalization is certainly not feasible, since financial resources are limited and there is no medical insurance to defray expenses. Prescriptions are also costly, and you may not be able to get the medication at the local "botica."

Time conceptualization also plays an important role in the attainment of health care for the Mexican American. First, a visit to a physician, hospital, or clinic usually requires a loss of work hours, which which reduces the paycheck. Second, an appointment has to be made and if the patient is late, he or she may have to wait twice as long before being called. Clinics are usually very crowded and staffed with volunteer medical professionals. The patient who has to return frequently for monitoring may have to deal with someone different on every occasion. This condition creates additional uncertainty about the modern approach to medical care from the point of view of the recipient. Further, validity of the treatment and the interest of the attending physician are also questioned.

So far, discussion has centered on the legal immigrant of Mexican heritage in this country. What about the undocumented alien?

Immigration and Naturalization Service records reflect that in 1977, of the 1,042,215 total apprehensions, 954,778 were natives of Mexico. These people come to this country basically to improve their economic situation. They, too, settle in the Mexican American neighborhoods where they can delay detection by the Immigration and Naturalization Service. This group of individuals basically has the same sociocultural adjustments. The lives of the undocumented are complicated because they must remain in constant hiding, for apprehension would only result in deportation to their native country. These people live in constant fear and when illness occurs, they defer any type of attention until absolutely necessary.

If you take all of these factors, plus population growth, into consideration, it is aparent that there is an increasing need to improve our health care system to meet the needs of Mexican Americans and all ethnic minorities. Each will have its individual medical problems, beliefs, and barriers to overcome. The most important criteria is basic communication and understanding between the recipient and the provider of health services.

Better utilization of community organizations could help to alleviate some of the social barriers between the recipient and the provider. Coordinative efforts could be initiated to achieve a closer working relationship between the community service organizations and the providers of health services.

The medical profession's recognition of and better understanding of the various social and cultural influences on the health attitudes of various ethnic groups could result in better acculturation.

Finally, I would like to close my remarks with a story one of my assistants told me. She was scheduled for a wisdom tooth extraction on an early Monday morning. The oral surgeon asked for her ethnic background since he was attempting to administer sodium pentathol and she insisted that a local would suffice. Much to the surprise of the physician, she responded, "Part Chinese, part Mexican." He pondered this for a while and said, "From the patients I have administered sodium pentathol, indications are that Chinese have a quick recovery rate while Mexicans have a slower recovery rate." She responded, "I guess that puts me somewhere in between."

Thank you.

DETERMINATION OF HISPANIC KNOWLEDGE, ATTITUDES AND PRACTICES RELATED TO CANCER FOR THE PURPOSE OF EDUCATION PROGRAMS

ROBERT W. DENNISTON
ROSE MARY ROMANO
National Cancer Institute
Bethesda, Maryland

Background

The National Cancer Institute (NCI), as part of the Department of Health, Education and Welfare (now Department of Health and Human Services), has a mandate to disseminate information about cancer to the public. Inherent in this charge is the notion of providing useful information to help people reduce their risks to cancer and to cope with cancer as effectively as possible.

Because cancer is both a highly diverse and complicated group of diseases and yet this Nation's most feared disease, communication about this subject requires a careful approach if we are to avoid increasing the public's sense of fear and confusion. Because some groups of people are at higher risk to cancer than other, however, an important element of NCI's activities to disseminate information is to reach those audiences at high risk in an effective manner.

Because the process of program development is critical to all communication efforts, our presentation will concentrate on how rather than what.

Program Development

Besides providing general information about cancer to the public, the Office of Cancer Communications (OCC) within NCI has under way varied approaches designed to reach important target audiences with specialized information. We try to determine what groups should receive special attention, and then work to develop information programs to reach these special groups. One such group is smokers, another is women at risk to breast cancer. Another is the Spanish-speaking population. How did we choose Hispanics as a special group? We used these criteria:

1. At high risk. Certain groups may be at high risk to developing cancer or at high risk to dying from cancer once cancer is contracted. People at high risk need to know of their risk and how to protect themselves.

In terms of cancer incidence, Hispanics are at a somewhat lower overall risk than Anglos and blacks. But it appears that, because of lesser access to and use of medical care, Hispanics are at high risk to dying of cancer once they contract the disease. Unfortunately, we can't say much about special risks, such as smoking, diet, and occupational exposures to carcinogens, because the data simply do not exist. Table 1 illustrates the relative risks to cancer.

TABLE 1. AGE-ADJUSTED (1970 U.S. STANDARD) CANCER INCIDENCE RATES PER 100,000 POPULATION, 1973-1977

Males		Females	
Black	436	Hawaiian	358
Hawaiian	426	White	297
White	361	Black	280
Japanese	284	Chinese	270
Chinese	255	Spanish - New Mexico	228
Filipino	232	Japanese	220
Puerto Rican	230	Filipino	200
Spanish - New Mexico	213	Puerto Rican	174

In areas where Hispanics constitute a major portion of the population, statistics give us a better measure of risk. In Texas, for example, where in 44 counties Hispanics constitute 35 percent or more of the population, the risk of cancer is lower for Hispanics than for either blacks or Anglos. Some 37,000 new cancer cases and nearly 22,000 deaths from the disease are expected in 1980 in Texas, but the share among Hispanics will be somewhat less than their proportion in the community.

3. Medically underserved. Some groups are disenfranchised from the health care system due to barriers, both real and perceived, of race, language, culture, and poverty.

Generally, Hispanics are medically underserved, although the situation seems to be improving somewhat. Access to medical care is often poor, and the private physician's office is usually avoided. Public clinics and hospital emergency rooms are utilized for reasons related to costs, convenience, and language and cultural barriers. But because use of health care facilities too often occurs only when a health problem has become serious, these episodic visits cannot provide the ongoing care needed for a good doctor-patient relationship and early cancer detection.

The National Center for Health Statistics reports that to receive health care, minorities must travel farther and wait longer than Anglos. Further, minorities are less likely to see a health care

professional of their own ethnic background, since less than 2 percent of health professionals are Hispanic. Minorities also tend to be hospitalized longer, have more serious health problems, and miss more time from work than Anglos.

4. Strong sense of fear and fatalism towards cancer. Cancer is the most feared disease among Anglos. Further, the sense of fatalism often is high, and myths about cancer abound. Most people, from what we know, believe there isn't much a person can do to reduce the risk to cancer. Often the idea that, "If you don't get cancer from one thing, you will get it from something else," is expressed. This view may be stronger among some groups than others, but we need to dispel this notion where it exists because such attitudes create a strong barrier to effective reception of health information.

   We don't know precisely what special fears and concerns Hispanics have about cancer. This is another area where definitive data simply do not exist. Anecdotally, however, the attitudes seem to be similar to other groups. For example, many people believe bumps and bruises can cause cancer. In our focus groups among Hispanics, this myth appeared to be widely held. And generally, cancer is a mysterious, feared disease that many people feel they are helpless to control.

Program Objectives

In developing this special audience information program, we set forth our objectives as follows:

1. Increase the realistic awareness of cancer.
2. Reduce myths and a sense of fatalism.
3. Provide information that people can act upon.
4. Increase prevention, self-detection, and medical consultation practices.

The messages we wish to convey are these:

1. Fear of cancer and avoidance of the subject can worsen the cancer problem.
2. Because of the progress being made against cancer, individuals can take action to: a) help prevent some kinds of cancer; b) find some kinds of cancer early; and c) seek treatment early and promptly for the best chances of control.

To carry out this program, we recognized at the outset that we must study the specific needs of the audience and the methods to reach the audience. To do this, we conducted a literature search and review to better learn how Hispanics obtain information about health and how this information is used. This exhaustive process is not yet complete

but it has provided us with useful information about the health information needs of the audience and about effective channels of communication. We have learned, for example, of the importance of local opinion leaders, and that often the curandero is favored as the best source of health care. We learned that although illiteracy often is high, perhaps 50 percent or more in the Southwest, of those who are illiterate, many persons speak Spanish but read and write in English. We learned that increasingly, Hispanic youth prefer black and contemporary radio to Spanish-language radio.

We learned of the popularity of novellas (soap operas) on Spanish TV. And we learned that, with at least 12 million persons now, Hispanics will become the Nation's largest minority group in about 1985, and by 1990 will likely be the majority in California. Larger, younger families mean a burgeoning Hispanic population, increasingly educated and affluent. And most, 85 percent, live in urban areas. We also discovered that although reading abilities vary (just one-half have a high school education) and regional language differences are found, a standard Spanish is appropriate for print materials, with careful audience testing and review.

As a national office with limited resources, we recognized that we should develop materials useful in communicating to any Hispanic audience. This means, of course, substantial review and some compromise because of regional differences. Because 60 percent of Hispanics in the United States are Mexican American, we most often elect to test our materials with this group. We also decided that print materials, because they are more likely to be influential with opinion leaders, are basic to this program, even though broadcast media may reach more people. Opinion leaders, who are more likely to be readers and to believe what they read as opposed to what they hear through the broadcast media, are important to the success of any communications effort.

To develop partnerships with organizations and individuals was the important next step, and later you will hear more about how the cooperation has worked. Partnerships with health organizations, community groups, and the news media are important to the success of these efforts. Without these partnerships, a Federal Government agency located in Bethesda, Maryland, cannot effectively disseminate information to individuals and groups around the country who have no reason to believe in a Federal agency or in its message. Therefore, this step in developing links with intermediary groups has been all-important.

Because we know that most Hispanics use neighborhood health centers and hospital outpatient clinics for their health care, we recruited as a partner the National Association of Community Health Centers which has more than 600 member centers throughout the Nation. And because leadership and interest in the community was highly important, we felt that the sponsorship of groups such as the Coalition of Spanish-Speaking Mental Health and Human Services Organizations

was important to the success of our program. The NCI-funded comprehensive cancer centers located in the areas of major Hispanic population also have been of great value to use in helping to determine format and content of materials, to test such materials in draft form, and, of course, to disseminate the materials we do develop.

As you should be able to tell by now, we believe that pretesting concepts and messages is a critical process in the development of education programs. To tell you more about the specific pretests we have conducted and about their results in materials development, here is Ms. Rose Mary Romano.

All informational materials produced by the Office of Cancer Communications are routinely pretested during communications planning and development. Pretesting initially is used: 1) to identify strategies for communications program planning and to identify characteristics of the target audience. Pretesting then is employed: 2) to identify those message concepts which have the strongest potential to communicate information to the target audiences. Once this selection is made and message format is refined, pretesting can be used: 3) to assess audience comprehension and recall of the message, to identify its communications strengths and weaknesses and to gauge sensitive or controversial elements of the message.

OCC uses a number of formative evaluation techniques to obtain audience feedback on messages and materials and these techniques have been used to design materials for our Hispanic project.

An initial project was the development of a general cancer information pamphlet, What You Should Know About Cancer, which is designed to provide easy-to-read, practical information about cancer, particularly prevention, detection and treatment, with an emphasis on actions an individual can take. Many cancer communicators working with Hispanic populations indicated that basic, core material did not exist and that such a booklet would be a useful tool for their information programs.

To develop this material, our first step was to determine what information should be included in the booklet. We looked at existing materials to determine what was available and what information was needed. This materials search was provided by NCI's Cancer Information Clearinghouse in its Bibliography of Public & Patient Education Materials in Spanish. Another source of information was a baseline needs assessment survey conducted in Los Angeles by the Los Angeles County/University of Southern California Comprehensive Cancer Center. This survey was the basis for a project designed to test the effectiveness of developing culture and language-specific cancer education programs and materials for Latino communities in Los Angeles to determine specific health care needs, with the primary emphasis on cancer education and information needs. Some of the issues identified were understanding causes and symptoms of cancer and attitudes about cancer patients. The results of this background work provided a framework for the in-

formation to be covered in the pamphlet.

As a second step, an initial draft was produced and sent to Cancer Information Service offices and other cancer centers that serve large Hispanic populations in Miami, Houston, Los Angeles, San Francisco, Boston, New York City, and New Mexico. The draft was also evaluated by members of the Coalition of Spanish-Speaking Mental Health and Human Services Organizations (COSSMHO) and the National Association of Community Health Centers (NACHC). This evaluation was used to determine:

1. The appropriateness of the information for Spanish-speaking persons in these areas;
2. The relevance and accuracy of the information;
3. The utility and appropriateness of the question and answer bilingual format, as well as the language, artwork and titles; and
4. Potential channels of distribution.

Following this professional review, the third step was to pretest a revised draft in Laredo, Texas, with a sample of 24 Spanish-speaking adults. Individual interviews, conducted in Spanish, were used to assess comprehension, readability and personal relevance of the materials and to gauge overall impressions of the information.

Results showed that respondents found the booklet to be informative, easy to read, and interesting. Most respondents found the Spanish appropriate with a few suggestions for word changes. Other respondents suggested an explanation of key words would help clarify the technical information.

The final step was to revise the booklet, according to the pretest results, for final production. In keeping with our intermediaries philosophy, cosponsorship was sought and received from the COSSMHO and NACHC, thus enhancing the credibility of this material and aiding promotion and dissemination efforts. Thus far, more than a quarter of a million of these booklets have been distributed.

Another program area is breast cancer education. Breast cancer is the most common form of cancer in American women (1 out of 14 develop the disease in their lifetime). For minority women, although the incidence is lower than that for white women, mortality rates appear to be higher. From a communication perspective, breast cancer is a high fear subject for the general public, yet early detection and prompt treatment increase the chances of surviving the disease.

Unfortunately, definitive data are lacking on public knowledge about the disease, practices related to detection, medical consultation, and other aspects of control. The most recent source of information is the American Cancer Society survey conducted in 1973. However, since that time, a great deal of public information about the disease

has been disseminated through the media, and there is reason to believe knowledge, attitudes and practices have changed substantially.

To provide such important program data, OCC this fall is undertaking a comprehensive nationwide survey entitled National Survey of Public Knowledge, Attitudes, and Practices Related to Breast Cancer, which will address the major public concerns related to the disease. In addition to a national sample of 1,500 women and 750 male spouses or partners, an augmented sample of 250 black and 400 Spanish-surnamed women will be included.

Extensive pretesting has been undertaken for more than a year to develop the survey instrument. Initially, focus group sessions were conducted around the country to probe for general awareness, concerns, attitudes and practices related to breast cancer. Results of these sessions served as the basis for our research hypotheses. Further, these results were used to determine the content and consumer language for the survey instrument.

Following the group sessions a preliminary questionnaire was designed and pilot tested. A major objective of this pretesting was to determine the appropriateness of the questions for Spanish-speaking respondents. Thirty-two full-length, personal interviews were conducted with Spanish-speaking respondents in three major Hispanic markets (New York, Miami and Fort Worth). The sample was composed of single women, women with partners, and male spouses or partners. Interviews were conducted in respondents' homes in Spanish or English, depending on the respondents' preference. Certain questions were used to test the hypothesis that some questions might have to be phrased more delicately because of greater modesty and sensitivity to the subject. This hypothesis was based on anecdotal statements that Hispanic women tend to be more modest in terms of touching their bodies or being examined by a physician and that Hispanic males are reluctant to have their wives examined by a male physician.

The results of these interviews indicated that the survey questions were, in fact, suitable for Hispanic respondents. Further, there appeared to be no unusual sensitivity concerning discussion of the subject. The additional concerns raised were not supported by pretest results, and among the sample studied, women seem to regard such examination in a positive sense. None of the partnered women reported their males as having a negative reaction to either breast self-examination or clinical exam by a health professional. Thus, these special questions were omitted from the survey instrument.

After further refinement of the questionnaire, another wave of interviews was conducted with 30 Spanish-speaking respondents in the three major market areas. Results again indicated the appropriateness of the questionnaire.

Another part of the breast cancer effort is an education program de-

signed to inform the public about the progress that has been made against breast cancer, particularly in early detection, diagnosis, treatment and rehabilitation. The program was developed to be used by corporations, voluntary groups, service clubs, religious organizations and other groups and is composed of a slide/tape presentation, a take-home pamphlet, a poster, series of articles for organizational publications and the Breast Cancer Digest (planner's guide).

The 17-minute slide/tape program focuses on a family and covers many social and psychological issues related to breast cancer. Through consultation with many health professionals around the country, it was determined that the program should be adapted for Hispanic audiences.

To ensure their appropriateness, program materials were pretested in Los Angeles with a sample of 24 male and female Spanish-speaking respondents. The objective of the pretest was to measure:

1. clarity and comprehension of the subject;
2. appropriateness for mixed audiences of men and women;
3. recall of specific information presented; and
4. attitudes and perceptions about breast cancer and breast self-examination.

After viewing the slide/tape program, respondents were asked to complete a questionnaire to find out what they learned from viewing the program. They then were divided into focus groups: two male groups and two female groups. These group discussions provided a wealth of suggestions to improve the materials. Many respondents found the Spanish used in the presentation was at times too technical and formal and should be simplified. Many also indicated that the presentation and the printed materials would be more effective in a bilingual format. Another result of the group discussions was a change in the main character used in the audiovisual presentation. Many respondents indicated that a smaller-breasted woman would be more suitable and less distracting.

The information obtained from these pretest efforts has provided guidance concerning information needs and insights for more effective communications targeted to Hispanic audiences.

To summarize what we have learned:

1. New materials are sorely needed and well received.
2. Explain technical or complex words and ideas. This can be accomplished through using parenthetical explanations, illustrations, and glossaries.
3. Bilingual formats are more useful than Spanish language only.
4. Standard or textbook Spanish is more acceptable to a range of groups than colloquial Spanish.
5. Need to use television and radio messages more for nonreading groups.

COMMUNICATING WITH MEXICAN AMERICANS

BY WORKING WITH AND THROUGH PROVIDERS

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A key element identified in some of the studies of health education programs is that health providers, especially doctors and nurses, are regarded as the primary and most credible sources of health information. The temptation in many health education efforts is to pay little or no attention to the provider-consumer communication relationship, but to teach consumers directly. The major thesis of this paper is that providers should be recognized as one of the most important channels for health education programs and, thus, as a first-line target audience.

In this sense, a major part of health education programs would be directed at understanding the provider-consumer relationship and at the development of communication strategies to effect desired behavioral outcomes.[1] The approach to be taken has three basic parts:

1. The initial phase of the health education-communication program is to change the behavior and attitudes of providers. Providers must be programmed as to the importance of their role in the educational process. They must understand that they represent the primary channel, both for information (facts) and education (persuasion to accept facts and change behavior). Providers, particularly physicians and nurses, must begin to see themselves as change agents. The emphasis would be on the development of prototype learning modules that could be incorporated into traditional medical and nursing education, as well as in ongoing continuing education efforts.

2. The second phase of the program aimed at providers is to give them a mechanism for categorizing their patient populations into identified consumer types. The emphasis would be on the development of profiles of consumer types, including communication strategies to produce desired behavior changes in each type, the assumption being that in order to perform their educative role they must first have knowledge of their patients' attitudes, values and behavior patterns.

3. The third phase would be to develop research-based materials that would be used to reinforce the educational efforts of providers. Providers must be properly programmed on the use

of health materials and should not rely on the materials themselves to produce behavior change. Since consumer types may respond only to certain kinds of stimuli, most materials would have to be aimed at a specific consumer type, i.e., appropriate materials produced for each type. Mass media messages would be used to create general awareness and to reinforce the educative role of the provider. That is, a specific medium, a newspaper for example, that has wide circulation within a target group may be utilized for a specific campaign that has the endorsement of health professionals. Again, messages would be designed to complement the educative role of the providers by extending their influence in the broader community.

Thus the overall approach consists of the development of specific communication strategies to be used in specific provider roles to influence specific consumer types. Included in this approach is the development of mechanisms to be applied by providers in order to segment consumer types, education and training of providers on how to exert proper kinds of influence through interpersonal communication, and development of materials and mass media programs in support of provider efforts.

Anatomy of Consumer Types

Barriers to good health and health care may be said to be of two types: objective and subjective.

Objective barriers involve a lack of certain desired elements in the individual's physical environment, or the individual lacks resources that would enable him to change his physical environment. Examples of objective barriers include lack of money, geographic isolation, lack of access to health professionals and lack of education.

Subjective barriers are attitudinal and operate as filters that alter how a person perceives information and, therefore, influence reactions to this information. Examples of subjective filters include social class, cultural bias, social and group pressures, perceived group memberships, and perceived expectations of significant others.

Health education/communication programs, if they are to be effective, must develop strategies to deal with both objective and subjective barriers. Objective barriers are dealt with through facilitating mechanisms which, in effect, take the place of the missing resources in the physical environment. Subjective barriers are dealt with through communication by the identification and analysis of the individuals' subjectivity and the context of what is meaningful to them.

Research on Consumer Types

Since the suggested approach hinges on our understanding of consumers' attitudes, values and behavior patterns, the author will devote the

rest of this paper to a discussion of a highly relevant research study conducted by Brenner and McCarty.[2]

Essentially, they were interested in the identification of both objective and subjective barriers in regard to nutrition and pregnancy. The study was conducted in a 15-county region of west Texas and included 90 consumers and 76 providers. The ethnic backgrounds of consumers were: Caucasian, 34 percent, Black, 10 percent, and Mexican American, 56 percent. The makeup of providers was: Caucasian, 68 percent, Black, 8 percent, and Mexican American, 24 percent.

They had both groups indicate their agreement or disagreement with a series of written statements and pictures about health, nutrition and pregnancy. The data were subjected to correlation and factor analysis. The endproduct was a set of factors, each representing a single set of statements or pictures, arrayed from the highest agreement to highest disagreement. The statement and picture arrays yield an expression of a distinct consumer type, and identify the characteristics of the group.

For purposes of this paper, I will describe only those four factors derived from how the subjects sorted the pictures. Providers and consumers were asked to sort the pictures as though they had "all the money they wanted," except that physicians and nurses were asked to sort them as they would like patients to do.

Understanding factor I. This group is most strongly defined by fathers and contains more males than any other group. All but one of the consumers are Mexican Americans. The educational level, at 7 years, is below average. The mean age is 32 years and income is below average. The group relies on physicians for general and pregnancy care as well as general health information. Relatives, however, were the major source of nutrition advice. As a group, these people subscribe to a philosophy that good health is a prime factor in a happy life and that nutrition is the key to good health. They like depictions of good health, while portrayals of health problems turn them off. There is a strong concern for nutritional aspects of pregnancy.

Communicating with factor I. In order to influence this group, health and nutrition must be associated with pleasant or happy situations. Communication with the group about health problems or portrayal of health problems that might occur with poor nutrition will produce negative reactions. To produce behavior change, people of this type must be persuaded that the new behavior will produce pleasant situations and good health.

Understanding factor II. This group is all Mexican American, mostly female, and averages 35 years of age, with a very low (5 years) average education. They are of below average income and have 4.3 children per family. They rely on physicians for general and pregnancy

care, but find relatives to be the most credible source of nutrition advice and general health information. The people are characterized by a social consciousness and an attitude of philanthropy. They are interested in improving their own situation, but, at the same time, they want to help others correct problems. They demonstrate a crusading spirit and a willingness to help others. They showed a particular concern for problems of pregnancy. The group identified with the plight of the poor and with situations it would like to do something about if given the resources to do so. The most favorable responses were associated with happy situations that indicated food was not a problem.

Communicating with factor II. Communication with this group is not difficult as long as communications efforts are carried out within their cultural context. Communications should take into account the reliance on the family, particularly mothers and grandmothers, for information and advice. Some mechanism should be utilized to influence the family, and not just the pregnant woman. Ethically and culturally, this seems to be a very cohesive group. To effectively change behavior, some facilitating mechanisms must be provided that can be seen and used as a resource that will allow people in this group to deal with their own problems and to assist others.

Understanding factor III. This group is all female and, in the majority, Mexican American. The average age is 29 years, average education 8 years and mean number of children per family is 3.3. There are similarities to factor II, principally in the ethnic makeup, but the factor III types are younger, better educated and exhibit less strong ethnic and cultural group cohesiveness. Factor III people rely on physicians as primary sources for nutrition advice, health care and general health information. Their basic orientation is toward the acquisition of health care services. Doing something about health is seen as important, rather than just being healthy. Good nutrition is seen as an active effort toward health and is considered important. This group associates the health care delivery system with being made healthy.

Communicating with factor III. This group will respond to communication based on the performance of positive health actions. The communication must be perceived by the audience as coming from a credible source, in this case health professionals. Behavior changes are sought in relation to preventive habits, including checkups for adults, and in relation to the importance of environment. Both these areas will require the facilitation of mechanisms and mass media reinforcement to supplement health professionals' advice.

Understanding factor IV. This group represents an extreme of low income, rural, and minority populations. They are the oldest group, with an average age of 40 and have the most children per family, an average of 8. Factor IV people rely less on doctors than other factors, both for general health care and for pregnancy care, and have

the greatest tendency to use folk healers, principally midwives. They are oriented to problems of the poor and medically indigent because they are members of that group. They have less contact with the health care system than other types and depend heavily on relatives for information and advice about health. This group sees the importance of nutrition in terms of being able to purchase a large quantity of food. They interpret good health care as having many health professionals available to take care of them. The major barrier to health services is perceived as lack of money. They tend to wait until health problems become severe before seeking health care from professionals.

Communicating with factor IV. This group requires enticement into the health care system in order to be properly benefitted. Since they perceive money to be their primary barrier, they must be provided with mechanisms that, in essence, take the place of money to obtain health services. This may mean, in some cases, simply acquainting them with existing free clinics, screening programs and other existing facilities to which they may go for care. In other cases new programs, or extensions of existing ones, may need to be developed and aimed specifically at the needs of this group.

Conclusion

The data from the study have indicated that health providers, for the most part, are usually the primary channel and the most credible source of health information. However, providers have no way, other than through intuitive observation based on experience, to segment their patient populations into groups according to types. This is why expanded research into the development of useful consumer profiles is the key element in the improvement of the provider-patient communication relationship. Once reliable and valid consumer profiles are established, providers would then have a basis for the selection of appropriate facts and appeals with the potential to effect desired behavior change. The locus of change is in the existing consumer attitudes, values and behavior patterns, rather than the creation of appeals to an idealized consumer who does not actually exist.

FOOTNOTES

[1] D. E. Costello, "Health Communication Theory and Research: An Overview," in B. Ruben (ed.) Communication Yearbook I, Transaction Books, New Brunswick, NJ, 1977, pp. 557-567.

[2] D. J. Brenner and R. H. McCarty, "A model for improving access to and utilization of regional health facilities through health education-communication programs." An unpublished manuscript of the Health Communications Department, Texas Tech University, School of Medicine, Lubbock, TX, 1975.

A REVIEW OF AN ORIENTATION PROGRAM FOR PHYSICIANS ENTERING MEDICAL PRACTICE IN A MEXICAN AMERICAN COMMUNITY

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My presentation today will proceed according to the following outline:

1. A review of the teaching program at the University of California, Irvine, and the patient populations served;
2. Strategy for introducing Anglo-American physicians to the Mexican American community;
3. A 5-minute excerpt from a 60-minute videotape on health practices and beliefs in the Mexican American community; and
4. A question period.

I. The Program at the University of California, Irvine

The department of family medicine at the University of California, Irvine, provides postgraduate training for physicians and undergraduate education for medical students. We currently have 45 family practice resident physicians in training. Young physicians from all over the United States enter the training program for 3 years of specialty training that prepares them for the practice of family medicine. Patients cared for during this training period are predominantly Mexican Americans who attend the university clinic in Santa Ana, Calif. The department also sponsors a program for undergraduate medical students. Under faculty supervision, they provide medical care in the Mexican American community of Santa Ana for one-half day a week for a year.

Thus, the department is host to a large number of providers who for the most part come from outside the Mexican American community and therefore, a proper orientation program had to be developed to introduce these providers to this community. The program has been summarized in a 60-minute videotape which is available at cost to anyone who would like to write to me for a copy.

In the meantime, today I will give you a general overview of our teaching program. Our program serves another purpose besides to provide the health care provider with insight into better ways to communicate with Mexican American patients and to therefore provide more effective medical care for the patients. The program also helps provide some insight to the young providers about the extent to which our own no-

tions of sickness and disease are themselves products of our own culture. We also discuss the many assumptions that come with our health care system, assumptions that may not be held by individuals who come from other cultural backgrounds. This kind of insight is extremely useful for any provider.

II. "Compliance" and Participation in our Medical Care System

Health care providers who come from the mainstream of Anglo-American culture to the Mexican American community for the first time often tend to see the Mexican American patient as "noncompliant." By "noncompliant," they mean a tendency for the patients not to take their medicines as advised, not to keep appointments properly, not to follow doctor's advice, etc. The extent to which this is true is inversely related to the relationship between the doctor and the patient and their mutual cross-cultural understanding. Therefore, as an introduction to the issues that may serve as barriers to understanding and "compliance," we begin our orientation with a review of the factors that have been shown to be related to "compliance" with therapeutic advice in any culture or any population. Table I summarizes the major issues in patient "compliance" with therapeutic regimens in any culture.

III. An Introduction to Mexican American Traditional Folk Beliefs and Their Consequences

The Mexican American people are at least as heterogeneous as the North American people of the United States. Within the country of Mexico there are at least 70 mutually unintelligible Indian dialects, as well as numerous Mexican subcultures in areas that have been geographically isolated from the rest of the country in the past.

Nonetheless, certain generalizations can be made that apply to many, if not a majority, of the Mexican American patients who attend our clinics. By and large, our patients are recent arrivals to the United States who come directly from rural areas of Mexico. Many of these patients are "illegal aliens" with limited educational background. In addition, many of these individuals share certain common views of sickness and medical care. Such generalizations will be helpful to the Anglo health care provider who enters this community for the first time. Table II is a review of some traditional folk beliefs that patients have on major diseases. These beliefs are based on their cultural backgrounds and may affect how they view their own sicknesses or how they interact with doctors in our own health care system.

In addition to a review of these traditional sickness models from Mexican American folk tradition, our program includes an orientation to ways in which the doctors' own practice styles and assumptions may

be foreign to the Mexican American patients, or perceived by them as impersonal and uncaring, if not strange. By the review of the issues and assumptions in both health care systems, the Mexican American traditional folk system and the Anglo system, we hope to improve the ability of the health care provider to open dialogue with the patients and to break down misunderstandings and cross-cultural barriers that may serve as obstacles to a good therapeutic alliance and good cross-cultural communication.

A brief review is given of the various types of traditional folk "healers" and country health care providers that are encountered both in rural Mexico and, to some extent, in the Mexican American barrios of Santa Ana and other areas of southern California. This review helps young physicians to understand the disease models and the types of medical care that many of the patients have experienced in the past.

IV. Generalizations Deriving From the Introduction to the Program

The health care providers are encouraged to approach the patient populations without too many suppositions about their beliefs, or their likelihood of accepting what the provider is likely to recommend. Our guidelines help define the tasks of family medicine, especially in the Mexican American population, and are also useful in the approach of any patient population. We summarized these tasks in table III.

The necessity for negotiated diagnosis, treatment, and medical care begins with a determination by the physician of what is wrong with the patient in the patient's own view, and what the patient views as a reasonably effective treatment for the condition. After these steps are taken, medical care can be negotiated that is acceptable to both sides.

In many instances, therapeutic advice will be given which is supplementary to what the patients may wish to do themselves to satisfy their traditional beliefs about health care. Thus, for example, in some instances the combination of manzanilla tea and antibiotics might be a perfectly acceptable negotiated therapeutic regimen. From Dr. Tittle's experience in Calexico, a good regimen is to tell diabetic patients not to eat sugar-containing foods, and to avoid chili and pork. These are just a few of the examples covered in an orientation program that emphasizes, above all else, meaningful communication.

V. Summary

Our introduction to health care for a new cultural group that is foreign to most of the health care providers who enter the community has enhanced physician-patient communication. We find fewer complaints from physicians about "noncompliance" and the physicians tend to take

a greater interest in the problems of their patients when they understand why they sometimes do things that they are not advised to do, and other times do not do things that they are advised to do. In the process, the physicians learn more about themselves and their own assumptions about the health care system where they have been trained. The result has been more sensitive, effective, and acceptable medical care for the community.

TABLE I. HYPOTHESIZED MODEL TO PREDICT MOST TYPES OF PATIENT COMPLIANCE WITH MEDICAL RECOMMENDATIONS.

Readiness to Undertake Recommended Compliance Behavior	Modifying and Enabling Factors	Compliant Behaviors
General Health Motivations Concern about health in general Illness as physical and social threat Willingness to accept medical direction Value of Illness Threat Reduction Perceived susceptibility (or resusceptibility) Perceived degree of possible bodily harm Perceived extent of interference with social roles Probability That Compliant Behavior Will Reduce Threat Belief in diagnosis Perceived efficacy of prescribed regimen Belief in efficacy of modern medicine Treatment meets psychological needs	Demographic (very old or poor) Structural (type, complexity, length, side effects of regimen; physician continuity; agency involvement; feedback to patient) Attitudes (satisfaction with visit, physician, other staff; clinic procedures and facilities) Interaction (length, depth, mutuality of expectation, and type of doctor-patient relationship; physician's faith in regimen; agreement with patient) Enabling (prior experience with illness or regimen; convenience; presence of symptoms; source of advice and referral)	Likelihood of: Compliance with regimens (drugs, diet, exercise, personal and work habits, followup tests, referral) Keeping followup appointments Entering or continuing a treatment progam

TABLE II. TRADITIONAL MEXICAN AMERICAN ILLNESSES
FROM TWO VANTAGE POINTS: FOLK AND PHYSICIAN

Symptoms	Folk Diagnosis	Folk Treatment	Physician Diagnosis
Upper abdominal pain Back pain Chest pain Wry neck	Aire (cold air disease)	Suction cup on back (ventosa) Herbal teas Prevent in sick infants by swaddling ("onion syndrome")	Angina pectoris Pneumonia Peptic ulcer Gallbladder disease For wry neck, viral myositis, pinched cervical nerve
Mid abdominal cramping pain with or without vomiting and/or diarrhea	Empacho (clogged intestine disease)	Massage of abdomen and back Herbal teas Occasionally purgatives	Gastroenteritis Gallbladder disease Appendicitis Intestinal parasites Food poisoning
In infants, Irritability, Excessive crying	Mal de ojo; mal ojo (illness from the eye; "evil eye")	Find person who looked at infant with strong glance and have him touch the infant Ritual cleansing with unbroken egg passed over body Prevent with red ribbon, amulet, or having person who looks at infant touch him	Food allergy Teething Ear infection
In infants, Fever Listlessness Feeding poorly Sometimes vomiting and/or diarrhea	Caida de mollera (fallen fontanel)	Upward pressure on roof of mouth Holding infant upside down over boiling water Applying moisturizing agents to fontanel Herbal teas Prevent by removing nipple slowly from infant's mouth	Dehydration from diarrhea or fever Malaise due to various infections (middle ear infection, meningitis, etc.)
Anorexia Insomnia Anxiety Hyperventilation Apathy	Susto (magical fright)	Ritual cleansing Herbal teas	Depression Anxiety reaction
Urinary frequency and/or pain with urination	Mal de orin (urine sickness)	Cornsilk tea	Urinary tract infection

TABLE II. (Continued)

Symptoms	Folk Diagnosis	Folk Treatment	Physician Diagnosis
Pulsing in the pit of the stomach (sometimes visible)	Latido (pulsing)	Herbal teas, e.g., tizana de indio Piece of bread or onion soaked in alcohol used as compress over pulse	Conspicuous abdominal aorta due to slender body build or emaciation
Bad disposition (irascibility)	Bilis (anger disease, lit. "bile")	Prevent by avoiding situations that cause anger bottle-feed infants to prevent transmission from nursing mother	Unresolved hostility Paranoia
Lower abdominal pain Infertility Discomfort during intercourse Rarely, uterine prolapse	Matriz caida (fallen uterus)	Postural and sometimes manual reduction	Pelvic infection, e.g. tuberculosis or gonorrhea Marital discord Rarely, true uterine prolapse
Virtually any chronically unresolved health problem	Mal puesto (a hex put on by sorcery)	Religious or magical cures, including burning of candles, ritual cleansing, sweeping patient with brooms to drive the spirits away	Chronic unhealing conditions (birth defects, epilepsy, tumors, anxiety, depression, etc.)

From Health Care in the Mexican-American Community: A Providers' Guide, by J. Dennis Mull, M.D., M.P.H., Kenneth Tittle, M.D., and Dorothy S. Mull, Ph.D., to be published early 1980.

TABLE III. TASKS OF FAMILY MEDICINE

Diagnosis and Treatment

- negotiated management of medical, psychiatric and social aspects of acute and chronic illness.

Teaching and Persuasion

- encouraging acceptance of therapy,
- illuminating the ways of disease,
- promoting patient participation in early diagnosis and prevention.

Support and Reassurance

- giving whole attention to the patient,
- understanding,
- seeking out concerns and sharing hope.

¿COMO TE SIENTES? - PREVENTING CHILDHOOD HEALTH PROBLEMS

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Lack of communications can lead not only to continued ignorance but also to the propagation of a sense of alienation. If you were living in a foreign country and knew only English and became ill, you would seek aid. You would have communication problems, not due to lack of intelligence, but to lack of knowledge of the language being spoken. Therefore, we believe that it is the responsibility of health authorities in our country to provide non-English speakers (in our case, predominantly Spanish speakers) with the means to care for themselves.

Our presentation is not designed to show off our medical knowledge, but, rather, to indicate why we need to provide children and their parents with information at an appropriate linguistic level. Additionally, we shall speak about methods to furnish them with guidelines instrumental for preventive medicine. Through bilingual education, the teaching of English as a second language, and in our professional duties, we have become aware of the linguistic barrier that Mexican Americans face. This lack of communication contributes to mistrust, apprehension and retrenchment among this group.

A recent study found that 3.6 million school age children have limited English proficiency.[1] Specifically, 1.7 million were children of Spanish-language background between the ages of 5 and 14. Another report indicates that in Texas about one-half of the children in grades kindergarten to three have limited English proficiency.[2]

Obviously, to instill good health practices among non-English speakers, cultural differences must be accomodated. Messages must be made available in the primary language at a linguistic level appropriate for the target audience. For example, the provision of material in grammatically correct Spanish is not sufficient if it conveys clinical information only understandable by the educated population.

This is not to imply that merely using incorrect Spanish will do the job. If the announcement is oral, voices must resemble those that a person from the barrio would associate with friends or neighbors. If the message is both oral and visual, a dubbed Spanish version which shows speakers who are obviously Anglo-Saxon will not be acceptable. In fact, it becomes laughable; hence, a joke or even an insult.

We suggest, therefore, that meaningful and easily understood information on preventive health habits should be directed to children when they enter public schools for the first time, as well as to those in the early grades. However, we recognize that this information can best be utilized and retained by youngsters only through family reinforcement. Consequently, we wish to discuss methods to encourage greater parental involvement. We shall focus on three examples of the many possible fields that can be profitably explored: immunizations, good nutrition, and regular physical examinations.

According to a May 1979 article, an estimated 30 million children in American receive inadequate medical attention. Some fail "to get vaccines that have long been available against an array of potentially crippling or even fatal diseases." The article says the inoculation rate is down to 70 percent nationally.[3] These percentages comprise two-thirds of the Nation's children, and are undoubtedly higher among Mexican American children. Several explanations exist for this situation among the latter group, particularly for those who live in the barrio. If one is to propose methods to communicate with Mexican Americans for their good health, one has to study the cultural and linguistic situations which medical authorities must understand. These findings will help medical personnel reach Mexican Americans and, more importantly, convince them of the validity of the information provided.

Thus, to provide information on immunizations is not simply a matter of sending a child home with a flyer. The information may not be clear; that is, a parent may not know how to read English. Or, if the paper is in Spanish, the parent may not be literate or may be frightened by the idea of having her child inoculated. Law requires that a child be immunized if he or she is to be admitted to school. If the first round of shots is administered, provisional admission is granted. This permission, even if temporary, may be interpreted by the parents as full compliance.

Why should something that we consider a routine matter cause misapprehension and even fear? Shouldn't the Mexican American mother see the value of inoculating her child? The clue lies in our own misunderstanding of their culture with its traditionally oriented patterns of behavior. During a recent interview with a Mexican American community clinic director, he indicated to me that "our traditions are our own worst enemy."[4] Because young mothers are still under the influence of their own mothers and well-intentioned elderly neighbors, methods will not be accepted that are inconsistent with the family way to treat an illness.

Furthermore, their inability to think in abstract terms is extremely difficult to overcome. When we speak of preventive medicine, we deal with a situation in which the child is not sick. The mother cannot accept the fact that medicine is being administered to her child when he or she is well. Besides, as has been pointed out to me, the mother

cannot bear seeing her child inoculated. The situation, particularly if the child cries, is much too painful for the mother. Besides, her own family has believed that a child should catch all the common childhood diseases at an early age, to free him or her from complications as an adult.

Patients are often blamed when they do not follow what is regarded as sound and scientific advice. One fails, however, to see things from their point of view. Is it not logical for them to trust a loved one or friends who provide ancient advice rather than to accept the new methods that seem so absurd since they contrast so sharply with past ideas? If we want these people to agree with our ideas, we should provide them with the same knowledge that motivates our behaviors before we expect them to change their habits based on their past knowledge.[5]

In order to change or modify a lifelong behavior pattern, we must deliver a message that is tasteful and attractive and that reaches them in terms that they understand. Spot announcements on local radio or television may give better results than instructions given in a clinic. What is heard and/or seen via the media is, at times, accepted as more credible, such as information that is telecast in Spanish and that portrays characters and situations which reflect the lifestyle of the viewer. If the parent begins to accept the idea of the value of immunizations, he/she will provide the involvement necessary to make the school's instruction on the same subject much more meaningful.

We propose that children, too, should be educated. They can be reached by a puppet presentation in the classroom or by slides that show, in a pleasant but informative manner, the various types of shots that are necessary and why they are needed at a given age. If students view this matter as beneficial, they can then take written information home. With both child and parent being exposed to the advantages of a proper program of immunization, the chances for success are increased.

We have included some handouts prepared by various agencies in the last few years that are attempts to provide information on immunization to Mexican American parents. While they are a step in the right direction, they do have their faults.

As far as we have been able to determine, the State Health Department of Texas prints in English and Spanish all materials used in public schools, which include those on nutrition and medical care. However, because of the possibility of illiteracy in the home, we suggest the use of nonverbal types of communication, or, ideally, a combination of aural and visual aids.

The National Dairy Council sends materials on nutrition to schools. They picture the basic food groups and bear a minimum of printed materials which could be translated easily into Spanish. The color pic-

tures can be used without change in the classroom. They can be copied for the child to take home to the parents, if the teacher so desires. Or they can be made into slides or transparencies for an illustrated lecture to parents, such as at a meeting called by the school nurse, perhaps in connection with a Head Start program, or in a videotaped program on health which would be presented on local television.

We suggest also the use of puppetry as a means to attract the attention of children and their parents and then focus that attention on good health habits. As Dr. Thomas Cassel remarks, the puppet can be a "mirror-self" of the child.[6] He/she can identify with and wish to emulate it. A puppet who loves to drink his milk and eat his carrots and spinach, who happily brushes his teeth twice a day, and who cheerfully goes to bed early, will be remembered far longer than a printed message on a mimeographed instruction sheet. Information on how to make puppets and to use them as teaching aids can be found in a tape series prepared at Wayne State University. The Center for Instructional Technology at this university will, upon request, assist in the production of other tape presentations. We have among our handouts several suggested puppet conversations.

The teaching of nutrition must stress the deglorification of fat as a sign of good health. The grandmother, la abuelita, will be the last to learn this lesson. To persuade young mothers not to listen to the pronouncements of their elders that a fat baby is a healthy baby will also be difficult. In our efforts to improve nutritional balance, we must remember that food habits are deeply ingrained in a culture. The diet of Mexican Americans is heavy with carbohydrates. Tortillas, beans, and rice comprise a large portion of their daily food intake. If proclamations on nutrition are written and delivered by people who accept and respect this facet of the culture and who attempt not to change but rather to add to the present diet, a greater degree of success will be achieved. John Steinbeck in Tortilla Flat dramatizes not only the typical daily diet of the lower income Mexican American family but also the cultural attitude which keeps that diet alive and well:

> At about this time in California it became the stylish thing for school nurses to visit the classes and to catechize the children on intimate details of their home life. In the first grade, Alfredo was called to the principal's office, for it was thought that he looked thin.
>
> The visiting nurse, trained in child psychology, said kindly, "Freddie, do you get enough to eat?"
>
> "Sure," said Alfredo.
>
> "Well, now. Tell me what you have for breakfast."
>
> "Tortillas and beans," said Alfredo.
>
> The nurse nodded her head dismally to the principal. "What do you have when you go home for lunch?"
>
> "I don't go home."
>
> "Don't you eat at noon?"

"Sure. I bring some beans wrapped up in a tortilla."

Actual alarm showed in the nurse's eyes, but she controlled herself. "At night what do you have to eat?"

"Tortillas and beans."

Her psychology deserted her. "Do you mean to stand there and tell me you eat nothing but tortillas and beans?"

Alfredo was astonished. "Jesus Christ," he said, "what more do you want?"[7]

This passage is a reminder that if the alternative nutritional habits we suggest for Mexican Americans are intended to complement, rather than to replace, their present ones, we will come closer to accomplishing our goal.

Children enrolled in a Head Start program get a general physical examination as part of their preschool program. Problems commonly uncovered relate to speech, hearing, and emotional disturbances. We have also learned that dental problems are much more widespread in the Mexican American preschool group than in other ethnic groups.[8] Obviously these children should continue a regular program of dental visits after the Head Start program terminates. The continued treatment of these and other problems is recommended by the school authorities, as well as regular physical examinations.

However, according to the laws of some states (Texas, for one) the child who receives medical care for any purpose, emergency or otherwise, must be accompanied by a parent or a guardian; therefore, the cooperation of the parents is imperative. Not only must they learn the importance of regular medical care, but they should know that the care is available without cost to people of low income. We recommend that mass media be employed to communicate with the parents. Television will reach a significant number of the target audience, and radio will reach the rest of them. We have prepared several sample videotaped skits which can fit into 15- to 50-second slots on television and which can also be taped as radio messages. Whether or not the specific subjects chosen for these tapes are pertinent to every health need under consideration, the idea and the format still prove very useful. As McLuhan put it, "The medium is the message."[9]

FOOTNOTES

[1] FORUM, Vol. II, No. 6, June/July 1979, p. 1.

[2] Jose A. Cardenas, Idra Newsletter, July 1979, p. 3.

[3] Edward Zigler, Susan Hensinger, "Look at the State of American Children in the Year of the Child," Idra Newsletter, June 1979, p. 2; reprint from Newsletter of Parenting, May 1979.

[4] Mario Cadena, Director, Dallas Community Clinics, interview, September 6, 1979.

[5] Jose Toledo, M.D. "Getting the Message to the People," formerly Medical Director, Maverick County Child Health Care Center. Especially recommended is his study, with Howard Hughes and Joe Sims, "Management of Noncompliance to Medical Regimen in Ethnic Groups: A Review of Six Pediatric Cardiology Cases," 1979, Department of Psychology, North Texas State University.

[6] Puppets and Children: Building Self-Concept, tape series and teacher's manual prepared by College of Lifelong Learning in cooperation with Center for Instructional Technology, Wayne State University, Detroit, Michigan, 48202. 1975.

[7] John Steinbeck, Tortilla Flat, New York: Penguin Books, Inc., 1946, pp. 124-126.

[8] In Denton, Texas, the Head Start program this year was composed of approximately one-third each Mexican Americans, Blacks, and Anglos.

[9] Herbert Marshall McLuhan, The Medium is the Message, New York, Random House, 1967.

SESSION II:

Health Values And Perceptions Affecting Communications

SESSION II: HEALTH VALUES AND PERCEPTIONS AFFECTING COMMUNICATIONS

KEYNOTE ADDRESS: JUAN ANTONIO CHAVIRA, PH.D.

Juan Antonio Chavira, Ph.D., assistant professor of clinical anthropology, department of family practice, University of Texas Health Sciences Center, San Antonio, Texas, is a well-known sociologist and medical anthropologist. He has conducted extensive research on the Mexican American community in the areas of curanderismo, health conditions, neonatal mortality, birth control, alcoholism and the impact of the aging.

Whenever we talk about values and perceptions of the Mexican American community to a professional group, or to personnel of agencies working in the community, I always get the impression that I am expected to map out "the territory" so to speak, so that others--yourselves in this case--can go in there and be better able to do your job. Indeed, one of the fallacies of modern education at all levels is the insistence of the "how to" approach. If we learn "how to" present our material, whatever it might be, then we can consciously believe we are doing our job. Unfortunately, the very nature of communication denies this one-sided outlook.

Communication can be defined as an exchange of information, a process by which meanings are exchanged by using a common system of symbols. Thus communication implies a sender and a receiver. But to be a truly dynamic and social model, the sender and the receiver must exchange roles: I communicate with you, and you respond by communicating back. There are intervals in which you are passive (listening, receiving the message) and I am active (delivering my message). There are alternate intervals in which I am passive (listening to see if you understood) and you are active (asking questions, making a point, or elaborating). A more important component of communication is meaning. In effective communication we do not exchange words or symbols, we exchange ideas, concepts, and feelings. This brief description may seem elementary to you, but it is necessary. Often in communication with the Mexican American community--about health, about drugs, about anything--we act very much like the college freshman: we are anxious to write our report before we have even begun to do our basic research. In this sense, communication is affected not by health values and health perceptions of the community, but rather by our own values and perceptions and the way we approach our target population.

A. Health. Take the term health, for example. Health care professionals really have no concept of health. We have a concept of disease, and we measure health by the absence of disease. Good times are generally associated with drinking, eating, and carousing, which are not very healthy activities. Moreover, I do not

think we believe in health. Sometimes I wonder whether we are trying to keep people healthy, or to just identify more disease.

B. Jargon. Some persons will call very selective and specialized language "terminology"; I call it jargon. While it is true that diastolic and systolic pressures are important, and that we need to have an understanding of how the blood vessels irrigate the body, most of this information is important to us in health care. What happens whenever we develop a communication exchange is that we end up talking to each other. The people in internal medicine like it, the people in outpatient clinics think it's OK, therefore the community should understand it and respond to it. For most people our heart is like our car: we do not know why or how it runs, and as long as it runs, we do not care. If the car stops running, only two things concern us: economics and inconvenience.

C. Technology. Oftentimes we get overwhelmed with the technology at our disposal, especially if we work at one of the larger health science centers. In this case the method--not the message--becomes the most important objective. We can produce slide series with music, we can record the lecture on video, and if we have enough money, we can even make a movie. Gadgets, whether they be cameras or computers, are meant to help us and not meant to be an end in themselves. There is a tendency among "professionals," especially those of us who are more insecure, to believe that the more technology we use, the more "professional" we are.

D. Education. Invariably, whenever we (the educated classes) discover a problem, whether real or imagined, among the less educated classes, we always come up with the same conclusion--educate them! As a result our barrios are now littered and polluted by an army of different agencies, church groups, volunteers, and salesmen "educating" Mexicans on sex, nutrition, family planning, social welfare, alcoholism and drug abuse, microwave ovens, and how to become Mormons. Mexican Americans are severely unemployed and underemployed, but our barrios seem to justify a lot of folks' salaries. There is a fallacy in this education approach for several reasons.

1. If education means teaching, then in order to teach something you have to know something. You have to know your subject matter and your target population.

2. We want our subjects to be passive, to listen and follow instructions. In order to teach, you must be willing to learn. We learn about ourselves, about our subject matter and about our audience. There is no way a person can become an effective educator and communicator until they have tried their strategies and ideas out in the field.

3. This is the most important one: we generally assume that people

out there--the ones we are to educate--have lived in a vacuum all their lives. They are empty vessels ready to be filled or empty cabinets ready to have all this information filed in them. Especially when one deals with health, Mexican Americans are not ignorant. They have definite concepts of health, and definite health values. The problem--if there is a problem--is that they have different priorities. To improve the health consciousness of Mexican Americans, then, we do not need new information or new concepts, we need to reorient priorities. Unfortunately, many of our families suffer from a multiplicity of problems and deal with various agencies. The problem then becomes which priorities do we reorient--sex, unemployment, high blood pressure, truancy, or do I just say the hell with all of them?

However, before I leave I suppose I may as well tell you something about health values and health perceptions of Mexican Americans. Generally, health is defined as the ability to do the activities which a person wishes to do and which contribute to his or her lifestyle, and to be with and enjoy the person or persons he/she loves. In a sense, health means integration into a network of significant others. Sickness, which is not the same as disease, means to be excluded from the above. You must have a very powerful and convincing message to convince a person to follow a certain diet and a certain lifestyle (no tobacco or booze) which excludes him/her from the group which gives him/her importance and recognition.

This last part is important because Mexican Americans respond differently by socioeconomic class. If a person's status depends on his or her job and his or her occupational and social position, he or she may respond to this approach. On the other hand, if a person's main reference group is the drinking group at Joe's ice house, then the approach should be different. In a so-called bilingual/bicultural group, communication occurs at different levels using variants in language and language function:

1. Intimate communication: family and loved ones;
2. Informal communication: peers, acquaintances;
3. Formal communication: institutions.

The use of language varies with age and education, however, for purposes of communication we can say that the more intimate the conversation, the higher the probability that it will be conducted in Spanish--except among our younger, more educated groups. Also, if health means integration into the group, and sickness means exclusion, then obviously health is an emotion-laden subject that hits at the very viability of the group. However, communication means an exchange using common symbols. In this case, the heart is an easy symbol to work with. The heart is the symbol for amor and cariño.

Un corazón enfermo es un corazón triste.
Un corazón enfermo no tiene la energía para querer.
Si tu me vas a dar tu corazón, no me lo des enfermo.
Si ud. quiere a su familia con todo su corazón, esté seguro que su corazón está completo.

It is not so easy to work with the liver or with the pancreas. In summary, it is not only important to know the values and perceptions of your intended audience, but is is equally important to know your own. In the long run it is easier and more productive to adjust your values and perceptions to those of your audience, than to expect your audience to change its values and perceptions.

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A STUDY OF ALTERNATIVE METHODS OF PRESENTING BILINGUAL HEALTH EDUCATION MESSAGES

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One of the important components of a successful health education program is the degree to which it is target specific. An important part of this specificity is to present the program in the language of the target audience. A problem arises, however, when the audience is composed of persons who speak different languages, a problem common in many countries and certainly in many areas in the United States with a sizeable Spanish-speaking population.

The goal of the project reported here was to evaluate the effectiveness of alternative methods to present health education messages in two languages by a slide/tape program. The site of the project was Houston, Texas, which has a large number of residents whose only language, or language of choice, is Spanish.

At present there are two methods used to present a message in two languages. The first of these methods involves the use of two sound tracks, one in English and one in the other language (in this case Spanish). This method is acceptable if the entire audience is monolingual in either of the languages, but if the group is composed of monolingual speakers of both languages the program must be repeated in the second language. A variety of problems arises as a result: 1) part of the audience will sit through a presentation they do not understand. When the program is replayed in their language, the visual stimuli are no longer new or interesting and less attention is often paid to the message, hence there is poorer retention; 2) the speakers of the second language (based on which sound track is played first) could conclude that they are a less important audience because their language was presented second; and 3) the speakers of the second language would become bored and leave the presentation while the program is still being presented in the first language; or jump to the conclusion that the program would only be presented in the first language as illustrated in the evaluation of the Satellite Instructional Television Experiment in India.[1]

An alternative approach is the use of a sound track which employs a consecutive translation. In this case the translation would be from

English to Spanish. Each segment of the English dialogue would be followed immediately by a segment of Spanish dialogue which conveys the same information. This method is less time-consuming than when the message is presented twice as with the above method. Part of the audience, however, does not understand the language being spoken at any given time. The boredom that results should negatively affect retention of the message. If bilingual people are in the audience (i.e., people who would get a "double dose" of the message due to the consecutive translation) two things could occur: 1) the repetition of the message may enhance retention, or 2) the repetition may oversaturate the listener which causes disinterest in the program. Additionally, the method of consecutive translation increases the length of the program.

In this study an attempt was made to compare these two methods with a third alternative. The third alternative involves the use of a single sound track employing a simultaneous translation of English into Spanish. This means the English dialogue is translated immediately into Spanish so that the two languages are heard simultaneously. This method alleviates the problems of the other two because the program is shown once in a time efficient manner.

We have the ability to listen selectively. This can be demonstrated easily at a party. One can choose to "eavesdrop" on a particular conversation, and although other conversations are going on simultaneously, these can be tuned out by the listener. This selective listening ability should be enhanced for the monolingual person when there are only two voices and only one of these speaks the language of the listeners. The bilingual individual in the same situation will have a predominant language to which he or she can "tune in" more easily. Additionally, education research indicates that individuals retain more information when there is a slight distraction and they are forced to pay attention more closely.[2]

Simultaneous translation is not a new concept. It is used internationally by governmental and business agencies as the most effective method of communication between persons who speak different languages. This study, however, is the first attempt to utilize the advantages of a simultaneous translation with a media presentation.

The simultaneous language translation sound track will, for the purposes of this study, be considered the most effective sound track if participants respond at least as accurately on a post-test when compared with responses to the other two sound tracks. If the amount of information retained is at least equivalent for the three methods, the simultaneous translation sound track will be considered to be the superior method due to more efficient use.

Methodology

A slide/tape program was selected as the appropriate media for this

project due to its low cost and the availability and portability of the equipment. The slide/tape media also allowed maximum facility in alternating the sound tracks.

An English version of the program to be presented was first prepared and translated into Spanish. To ensure identical content of the two versions, the Spanish program was retranslated back into English by a translator naive as to its content. The two English versions were then examined and found to be essentially alike.

Three sound tracks were developed for use with the slides. The dialogue was originally recorded on a master tape. Women's voices were used to record the message as the audience was to be composed almost exclusively of women. A native English speaker recorded the Spanish segments. Two different voices were used because the voices of native speakers were considered to be more palatable to the respective audiences, and two distinct voices would minimize the competition of the voices on the simultaneous translation sound track. Attempts were made to choose voices of relatively similar intensity and pitch to minimize the possibility that one voice would dominate. The levels of the recordings were equalized through the use of a 60-cycle tone recorded at the beginning of each master tape. One master tape was prepared for each language and used to produce all three sound tracks on tape cassettes.

The monolingual sound tracks were copied from the master tape. In the first cassette, the complete Spanish sound track immediately follows its English equivalent. In the second cassette, the consecutive translation sound track was prepared as follows: each master tape was copied and the individual segments of dialogue were spliced together so that each English segment was immediately followed by a Spanish version of that segment.

The master tapes were also used for the preparation of the simultaneous translation sound track. The simultaneous synchronization capabilities of a two track tape recorder were used to copy the English master on one track of a tape. The Spanish version was then recorded on the other track with care taken to equalize the segment lengths. The beginning of each overlapped segment was staggered so that one voice would begin before the other. This allowed for each member of the audience to "tune in" to his or her language. This tape was then copied on a cassette with both voices on one track.

The English sound track is 9 minutes, 34 seconds long, and the Spanish is 11 minutes, 47 seconds long. The length of the consecutive translation sound track is 17 minutes, 17 seconds and the simultaneous sound track lasts 12 minutes, 31 seconds. On every sound track, each segment of dialogue is followed by a brief pause for the slide change.

The content for the slide/tape presentation was designed to explain the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

which provides medical screening to government Medicaid recipients under the age of 21. The presentation encompassed a general overview of what the screening was about, enumerated the services provided by the social worker, familiarized the audience with the forms used, the transportation services, appointment procedures, etc.

The target audience for the presentation was the mothers of children eligible for the screening who were either recipients of Aid to Families with Dependent Children or Supplemental Security Income. The educational level of these mothers is generally low; most have not completed high school and many are functionally illiterate. Even the English speakers often arrive at the screening clinic with little idea of the reason for their appointment. One woman thought she was at the clinic for a health "screaming." This lack of knowledge inhibits the active participation of the parents in the screening process and their ability to ask relevant questions of the clinic staff. The problem is compounded for the Spanish speaker who must bring a translator or depend on the language skills of one of her children in order for her to communicate with the clinic staff.

The slide/tape program was presented in four places. Two of the locations were city of Houston health clinics which perform the EPSDT screenings--Berry Road Clinic and Riverside Clinic. The slide/tape program was presented three mornings in each clinic with each sound track used on only one morning.

Morning appointments in the clinic are scheduled for 8 or 10 o'clock. Those parents who arrived for 8 o'clock appointments were given a pretest to assess their level of knowledge of EPSDT prior to when they viewed the slides. After the slide show a post-test was given to determine both the understandability of the sound track and the amount of retention of information. Those parents who arrived for 10 o'clock appointments received only the post-test to control for any bias associated with pretest sensitization. The pre-/post-test was designed for people who may or may not be literate. The test consisted of 10 questions. Each question was read aloud and the participants were asked to circle an X or an O on the answer sheet to indicate whether they agreed or disagreed with the statement that was read. The answer sheet was color-coded as well as numbered to alleviate any problems due to lack of familiarity with the numbers.

The last phase of EPSDT screening was an exit interview with a social worker. During this interview, the social worker asked each parent for any comments she or he had about the slides or the sound tracks and whether they learned anything from the slide/tape show. The interview was conducted orally and the social worker recorded the answers and comments on an answer sheet.

The slide/tape program was also shown to a vocational rehabilitation orientation class, a joint project of the Texas Rehabilitation Commission and the Texas Department of Human Resources. The class lasts

for 2 months and helps to prepare the mothers in the class for the working world. All mothers are recipients of Aid to Families with Dependent Children and Medicaid recipients and hence EPSDT eligible.

In order to place their children in commercial day-care centers, the children must have a physical examination. This requirement is met by having the children participate in the EPSDT screening. Because of the length of the class, the slide/tape program could not be presented with each of the three sound tracks to three distinct groups of mothers. Therefore, only the simultaneous translation sound track was used with the slides. The group was both pre- and post-tested. After the post-test, a question/answer/comment session was conducted.

In addition to the presentation of the slide/tape program to the parents of children who were eligible for the program, the slides with the simultaneous sound track were also viewed by a group of 10 students from the University of Texas School of Public Health. Eight of the ten students were bilingual (English and Spanish). None had any previous knowledge of the EPSDT program. This group was post-tested only. The slide program was shown to this group in an attempt to ascertain the effect of educational background on the ability to understand the simultaneous translation sound track. The high number of bilingual students in the group also promised to provide interesting information on the ability to choose which language to listen to on the simultaneous translation sound track.

Results

The data were analyzed by a comparison of group mean scores. Table 1 enumerates mean scores by sound track and by test group. (The maximum test score was 10.)

A total of 31 parents heard the monolingual sound track presentation. Of these, only 19 received the pre- and post-test and 12 were post-tested only. Of the 16 participants who heard the consecutive translation, 10 were pre- and post-tested while the remainder were only given the post-test. Of the 39 people who listened to the simultaneous translation sound track, the 13 members of the vocational rehabilitation class were pre- and post-tested, as were 11 parents who viewed the program in the clinics. The 10 university students and 5 additional parents who participated in the clinics received only a post-test.

The greatest improvement in test scores for the pre- and post-test group occurred in the group that viewed the slides with the consecutive translation. An increase of 1.7 points occurred in this group's scores compared with an increase of 0.43 for the monolingual sound track group and 0.64 for the simultaneous sound track group. For the group who received only the post-test, however, those who viewed the slides with the simultaneous translation sound track scored 1.0 point higher than the monolingual sound track group and 1.1 points higher

than the consecutive translation sound track group. The scores for the vocational rehabilitation class (simultaneous translation sound track) improved by 1.37 points from a pretest mean of 8.27 to a post-test mean of 9.64. The group mean for the University of Texas students who heard the simultaneous translation sound track was 9.88.

With the exception of the university students, groups who received a pretest scored higher on the post-test than did those who were post-tested only.

Discussion

Due to the small sample size and the lack of dramatic difference in mean scores, no firm conclusions can be drawn from these data. However, an important observation is that test scores improved for all groups between pre- and post-testing and that those who listened to the simultaneous translation sound track performed adequately on the post-test.

Also meaningful for this analysis are the subjective data collected by the social workers and the comments and suggestions of the participants to the investigator during the question/answer/comment sessions after the program was viewed.

All persons who viewed the slide show with the monolingual sound track felt that they learned something from the program, ranging from how to get transportation to the value of the EPSDT screening. None expressed any hearing or listening difficulty. The most interesting point elicited here was that all the viewers were pleased that someone would provide them with information in an informative but entertaining manner. Although a few of the participants were intimidated and threatened by the experimental format and the use of a required informed consent form, the program was enthusiastically received by the overwhelming majority.

Those participants who viewed the slides with the consecutive translation sound track had very similar comments to those above. Again, all felt they learned something from the program and none expressed any hearing or listening difficulty.

The simultaneous translation sound track evoked more comments from the participants in the clinics than the other two. Although a few participants said they had some difficulty listening to this sound track, all felt they learned something new about EPSDT and all indicated how much they enjoyed the entertainment of seeing slides in the clinic. The most frequent comment was that a few sentences were needed to become accustomed to hearing the two voices and to choose one or the other to listen to. Once this had been done, however, the vast majority of participants were surprised to find that they could listen to the language they had chosen with a minimum of difficulty.

Bilingual participants' comments ranged from difficulty in deciding on which language to listen, to feeling that the message was being reinforced by hearing it in both languages. On the whole, those participants with more education expressed less difficulty in selecting and listening to one or the other of the languages.

Although the data from this experiment is inconclusive, the comments from the participants and the positive reception of the simultaneous translation sound track indicates the need for continued research in this area. This slide/tape program attempted to present elementary information to an undereducated population. The same format could be valuable to deal with a more complicated subject matter directed to a more highly educated audience.

The value of a breakthrough such as this to provide information to a group of people who do not all speak the same language is not restricted to the area of health education. The impact can be extrapolated to bilingual education in general and will be of value not only with regard to health care, but also in school, government and private industry. More research is warranted to expand upon the results of this study.

FOOTNOTES

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TABLE 1.

Sound Track Group	Test Group	n	X
	Clinic Pre- and Post-test		
Monolingual			
	Pretest	19	8.57
	Post-test	19	9.00
Consecutive			
	Pretest	10	7.70
	Post-test	10	9.40
Simultaneous			
	Pretest	11	8.45
	Post-test	11	9.09
	Post-test		
Monolingual		12	8.60
Consecutive		6	8.50
Simultaneous		5	9.60
	Vocational Rehabilitation		
Simultaneous			
	Pretest	13	8.27
	Post-test	13	9.64
	University Students		
Simultaneous			
	Post-test	10	9.87

Comparison of group mean scores by sound track and test group.

ANTIHYPERTENSION STUDY IN A PREDOMINANTLY MEXICAN AMERICAN POPULATION

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The El Rio Santa Cruz Neighborhood Health Center began with a U. S. Department of Health, Education and Welfare (now Department of Health and Human Services) grant and has been in operation since October 1970. The health center is located in the heart of the Model Cities area, a 10-square-mile section which encompasses 59,000 people in the southwest part of Tucson. The center offers family oriented health care to about 41,000 low income residents. We moved into a new facility in July 1977. The ethnic composition of the population is as follows:

Mexican American	78.0%
Anglo	10.0%
Black	9.5%
Other (American Indian, Vietnamese, and Chinese)	2.5%

A need survey in 1968 identified hypertension, diabetes, heart problems, alcoholism, drug abuse, and malnutrition as the biggest health problems in the area.

In October 1977, the neighborhood health center was awarded a grant from the State of Arizona Anti-Hypertension Program to study drug compliance in hypertension patients who received medication counseling on an individual basis. The intent was to discover if the 1:1 pharmacist to patient relationship has any significant bearing on the patient's compliance with medication. This study was a unique opportunity for the pharmacists at the neighborhood health center since all four pharmacists speak Spanish and fill prescriptions for the patients of the center. A pharmacy aide helps the pharmacist keep records and schedules followup on patients. A pharmacy student helps counsel. Community family health workers are also used on home visits when problems are encountered with blood pressure or medication compliance and patients need followup at home.

Some criteria were first established to start the program and to meet the requirements of the grant:

1. The patient must have a primary diagnosis of hypertension.
2. The patient must be undergoing treatment with chemotherapy for high blood pressure.
3. The patient must be ambulatory.

Procedures were established for a referral system from the physicians and nurse practitioners to enroll patients in the program. Patients are also asked to participate in the program by the pharmacist when their blood pressure medications are filled.

When the patient arrives for the appointment, he or she is seen in a private setting. The pharmacist reviews the patient's hypertension record used exclusively in the program. The medical record is also reviewed for the patient's history of blood pressure and drug regimen. The drug regimen is entered in the patient's medication profile. The blood pressure is taken by the pharmacist and entered in a blood pressure flow sheet. In counseling, the importance of medication compliance is emphasized. The patients are also asked to bring in their medication so the pharmacist can review and discuss the directions with the patient.

The pharmacist uses a variety of techniques to decide whether patients comply with their regimen. The average appointment is 15-20 minutes long. New patients may have 30-minute appointments because of the collection of new records. The health educator and dietician services are also part of the program. Patients are referred for weight reduction classes. We also use films and tapes as additional teaching aids. This repetition aspect has helped patients understand the importance of their compliance with the medication. As the patients begin to see the results, they follow their medication regimen faithfully.

New patients in the program are seen once a month for 3 months. If they improve, they are scheduled for appointments every 2 or 3 months. After a few sessions, the patients can see the apparent "we care" attitude of the pharmacists and they become more relaxed, more attentive, and ask questions. Literature on hypertension is given to them in a packet at the start of the program and additional diet sheets are used as the need arises.

The 1:1 relationship has opened the door for other patient concerns, such as alcoholism and other medical complaints, which the pharmacist refers to physicians or agencies which deal with the specific problem. As we talk to the patients, we ask if they have had any discomfort or symptoms that may indicate a drug reaction. Recognition of drug reactions is a very important part of the counseling sessions since patients may not comply because the medication may make them feel sick. At this time we also inform the patient that the side effect is a normal reaction and is to be expected. We try to dispel any fear or apprehension experienced by the patient about the medication.

A patient followup system is used to keep the patients interested and to keep them enrolled in the program. If the patient does not show up for the appointment, the pharmacy aide calls the patient to reschedule. If the patient can not be reached by phone, a card is sent to the patients which asks them to call us to reschedule. Those patients who do not respond to the cards are called again within the month of

the appointment. Some patients unable to keep their appointments will call us on their own initiative to reschedule. The hypertension clinics are held all day on Wednesday and half-day on Thursdays. Patients who are unable to attend during the day are scheduled after 6 p.m. on Thursday evening. In an all day clinic, 18 patients are seen on an average.

Quarterly progress reports are submitted to the state hypertension program. Although the medication compliance is difficult to measure, the results indicate that the number of normotensive patients has increased steadily. For instance, in December 1977 when the program was started, 27.2 percent of the patients were normotensive. At the end of the first year, September 1978, 78.2 percent of the patients were normotensive--an increase of about 50 percent. These figures are based on the number of patients seen per session. In comparison with more recent figures, we find that in June 1979 there were 89.2 percent normotensive patients. The program now has over 500 patients enrolled, with 80 percent of patients still active. Most of the referrals to the program are now made by the 22 physicians and nurse practitioners. We average 20 new patients per month.

A separate and important study has evolved from the program. As part of his doctoral thesis, a psychology student used volunteer patients in our program to gather information for his study on "Hypertension and Life Stress." His study centered on the question, "What effect do low economic factors have on stress and hypertension?"

Our pharmacists feel that formal training of other health personnel should be done and coordinated with the health education and dietician departments. The objective of the training would be to develop a program which would take care of more patients, and would be economically feasible in any organization.

The grant has given the pharmacists at El Rio Santa Cruz Neighborhood Health Center the opportunity to make better use of their pharmaceutical knowledge and to convey to their patients that they are an important component of the health team.

ESPERANZA: A VIDEOTAPE PACKAGE TO REACH HISPANICS WITH CANCER HEALTH EDUCATION

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Abstract

The goal of Esperanza is to decrease the mortality and morbidity rates of breast, cervical, and colorectal cancer through the use of early cancer screening services by high-risk (over the age of 40) Spanish-speaking individuals.

Rationale

Determination of the need for the Spanish language videotape was based on a media search conducted by the New Mexico Cancer Control Program for appropriate linguistic educational materials on cancer for southwestern Hispanic populations. The selected disease sites for the videotape include breast, cervical, and colorectal cancers. These types of cancer are the most epidemiologically common among Hispanics in the region.

This determination was made through data analysis on the numbers of cases and deaths, crude and age-adjusted incidence rates by ethnic group and stage of disease, and age-specific incidence rates by ethnic group and stage of disease. These data were provided by the New Mexico Tumor Registry which is a member of the Surveillance, Epidemiology, and End Results (SEER) Program.

Demographic information played an important part in the decision to produce a videotape which would be easily transportable to the medically underserved areas of the region to reach the high risk target population. A leader's guide was also developed to accompany the videotape so that the presentation may be utilized by a health care professional in the absence of a physician.

New Mexico is the fifth largest state in the union with 121,666 square miles, an area equivalent to Maine, New Hampshire, Vermont, Massachu-

setts, Rhode Island, Connecticut, Ohio, West Virginia, Delaware, and the District of Columbia combined with room to spare. The state terrain varies from desert in the south, to mountains and pine forests in the north. The largest city in the state is Albuquerque with a population of some 360,000. The state capital is Santa Fe, some 50 miles north of Albuquerque.

The 1977 estimated state population was 1,126,900, with approximately 30 percent located in rural areas. The actual medical catchment population exceeds 1.5 million.

The videotape is aimed at a high risk Hispanic population which includes men and women over 40 and those individuals with a family history of cancer. The hard to reach population is located in medically underserved rural, oftentimes isolated, areas of the state. This population is characterized by a low socioeconomic status. Per capita income is 43rd of the 50 states at $6,505, compared with a national average of $7,810. The average educational attainment level of the Hispanic population is 9.7 years.

The state population is multicultural: 52 percent are Anglo, 38 percent are of Spanish/Mexican heritage, 2 percent are black, and 7 percent are Indian. Major Indian groups in the state and region include the Navajo at 150,000, the Pueblos (19 tribes) at 25,000, and the Apache at 3,345. The rural areas, where one-third of the population lives, are medically underserved.

To say the population of this region differs greatly from other parts of the United States is an oversimplification. Many of these groups also differ from each other in terms of cultural traditions, mores, lifestyles, and languages. For example, languages spoken in the region include two New Mexico dialects of Spanish, as well as Apache, Navajo, and 17 different Pueblo tongues. For many, English is a second language, and some (particularly older people living in rural areas) speak little or no English at all.

Many members of these cultural groups lack ready access to health care, especially in medically underserved rural areas. Preventive health care knowledge is very limited in some areas, and cultural traditions and lifestyles inhibit conventional medical practices among some groups. Medical treatment frequently is limited to "curative" or "emergency" care, and thus cancers which occur in the target population often are advanced by the time they are detected.

Specific objectives were set for the videotape viewers after exposure to the instructional package which includes a leader-led discussion. The participants should be able to:

1. Determine the videotape's ability to reach the high-risk Hispanic population.
2. Recall specific facts about cancer in the three target sites.

3. Increase their utilization of early cancer screening services due to the awareness of cancer information presented in the program.
4. Display a reduction of fear of cancer screening by identification with the positive role models presented which use screening procedures in the program.

Funding

Exploration for funding Esperanza began over a year before it was actually obtained. The production was originally conceived as a 16mm film aimed at Hispanics on the topics of breast cancer and mastectomy. An abstract was developed by the authors and an outside media consultant and was circulated among the appropriate divisions of the National Cancer Institute, which deemed the project too costly.

A significant contact within the NCI suggested a less expensive medium such as slide/tape or videotape and an expansion of the theme, i.e., the use of two additional disease sites with significant incidence rates among Hispanics. Consequently, the three target sites were chosen (breast, cervical, and colorectal), the medium was changed to 3/4" videotape, and plans were made to include a leader's manual.

The abstract was rewritten and again circulated at the NCI. Considerable interest was shown in the project but funds were not committed. However, the NCI contact person suggested an alternative approach to obtain funds.

New Mexico has an in-place Cancer Control Program (NMCCP) with established subcontract mechanisms and subcontractors. With assistance from NCI, the NMCCP was approached with a draft proposal for the production of Esperanza under a subcontract arrangement. Months passed before the NMCCP and the NCI reached agreement on the concept, methodology, and reallocation of funds.

A final proposal was then developed, submitted to NCI through the NMCCP, and approved for implementation in December of 1978, and a 6-month contract for $38,000 was negotiated.

Treatment and Approaches

Based on previous successful media production experience with New Mexico populations, present patient cases which were positive were used to reach the objectives to alleviate the fear of cancer and to promote the importance of early detection and diagnosis. In addition, the videotape was shot on location in recognizable New Mexico locales. Flashback techniques were utilized as each of the three patients related their experiences which included diagnosis, psychosocial problems, treatment, and rehabilitation for their cancers.

In recognition of the linguistic differences between northern and

southern Spanish-speaking Hispanics, and the need to make the videotape as applicable as possible with other southwestern Hispanics, a determination was made to use Spanglish. This dialect is a common mixture of Spanish and English which is spoken in the state and region.

Since the location of actual cancer patients and families who could endure the rugged shooting schedule was difficult, amateur talent from New Mexico was utilized. The cast also included two New Mexico Hispanic physicians. The locations where the videotape was shot included urban and rural settings recognizable in the Southwest.

In summary, these approaches were intended to:

1. Provoke viewer interest in the presentation through the utilization of cases to present cancer information.
2. Provide positive role models through the cast.
3. Demonstrate positive physician-cancer patient relationships as well as family interactions.
4. Demonstrate that Spanglish is a satisfactory linguistic medium to reach speakers of the several different dialects of Spanish in the region. (Ongoing field testing should prove or disprove this assertion.)

A pretest is administered prior to the showing of the 28-minute videotape and a post-test is administered immediately afterward. A leader's guide is utilized to facilitate discussion of the videotape among the viewers.

Evaluation

An evaluation plan for Esperanza was developed and included in the final proposal. During script development, medical information and appropriateness of language were verified by NMCCP and NMHC staff and others. The script was prepared by a physician and was reviewed by three other physicians for accuracy.

Other preliminary evaluation steps were targeted at the appropriateness of the actors, the settings, and locations. Final selection was measured by the expressed need for Hispanic actors, typical and real clinic settings, southwestern terrain, and rural and urban settings.

Translation of the script to Spanglish was completed by a NMHC staff person with assistance from a number of Spanish-speaking individuals. Although there remains a minor controversy over the regional dialect used in the film, recent reviews at showings in Texas and northern and southern New Mexico have judged the language as generally appropriate. The technical quality of the production was continuously evaluated and accomplished under the direction of the New Mexico Public Programming Corporation.

Postproduction evaluation instruments were designed and are currently in use to measure the following:

1. The realism projected by actors.
2. The comprehension of the Spanish used.
3. The clarity and relative knowledge of information presented.
4. The effects of the videotape on behavior change as it relates to cancer screening.
5. The age and sex of viewer.

Current data available are outlined in the evaluation summary.

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PRELIMINARY EVALUATION SUMMARY OF VIDEOTAPE WITHOUT ACCOMPANYING LEADER'S GUIDE

8/1/79 - 9/1/79

	Yes	Somewhat	No	No Reply
Realism Projected by Actor	61%	24%	12%	3%
Comprehension of Spanish	67%	18%	12%	3%
Increase in Knowledge	67%	18%	6%	9%
Would Change Behavior	52%	0%	42%*	6%

Viewers

Males	20
Females	13

Age

Under 25	3
26-39	22
40-55	8

* Of the 42% who stated their behavior would not change, 7% said that no money was available, 36% have annual physicals, and 14% simply did not care.

RETURN OF THE MEDICINE SHOW

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Most of us concerned with contemporary health communication efforts know about the bygone early American occupation of the medicine showman, his tent shows and patent medicines, the likes of which are now only found in our local drugstores. The medicine showman has faded from this country's communities, but in Mexico he remains a major source of health information for the relatively deprived. For the past 6 years we have studied the phenomenon of the Mexican medicine showman, the merolico, and we appreciate this opportunity to share with you some of the more salient aspects of the study and their importance for health communication efforts in Mexican American communities.

How did research on medicine showmen get started? In 1968 one of the authors was in Oaxaca, Mexico, for a year to do research for his dissertation. While in Oaxaca, he had often looked at medicine showmen and their audiences and had listened to many of the sales pitches. However, he did not see what was occuring and begin to understand its social meaning until one day close to the end of his stay. On this day he realized that medicine showmen's audiences were not composed of just passers-by who stopped to be entertained for a few moments. Facial expressions and undivided attention indicated a seriousness of thought, and the observed purposes indicated a commitment to proposed solutions. The medicine showman obviously knew how to effectively communicate health information to his audience and in some way satisfy their health-related needs.

At that point one could not be sure why the medicine showman functioned as an effective communicator of health information or what audience needs were being satisfied. But here was a public scene in which someone successfully did what public health personnel around the world have for the most part unsuccessfully tried to do, and used great expenditures of money and time in the process--that is, effectively communicate health information to those who most need it. The thought arose that this type of street scene could be used in public health programs.

The actual study did not begin until 1973. We knew any initial research

effort should be directed at confirmation of the medicine showmen's effectiveness as communicators of health information. Field research[1] conducted in 1974 found the medicine showmen to outrank all other sources of health care as individuals who "give important information, explain well, and are accessible." Clients interviewed gave the medicine showmen the highest overall composite ranking of the 10 sources of health information. Although they ranked only fifth in competence, they ranked first in credibility and first in usefulness. On the similarity criterion they ranked second only to the clients' own families.

Medicine showmen gain the attention of their audiences by entertainment, by concentration on the objective relationship between poverty and health, and by recognition of the subjective element of anxiety connected with inadequate knowledge about health care and resources to obtain such care. Katz, et al. (1973) emphasize the extent to which mass media are unsuited to deal with these personal problems and the immense salience of personal contact in such cases. Medicine showmen provide such a contact, and apparently provide one solution to the problems of knowledge and resources. Like other mass media channels, medicine showmen work swiftly on the basis of a certain uniformity of message, and reach a fairly large target population (at times 75-100 people). They are also able to be intimate and can customize messages for specific audiences.

Such a channel of communication may be appropriately termed "local media."[3,4] Local media are interstitial linkages which tie together mass media and interpersonal channels. Mass media channels are often used to diffuse information about modern scientific medicine. Lay referral systems, which are comprised of interpersonal channels, function to put clients in touch with sources of health information and health care. Medicine showmen link these systems very nicely. Furthermore, the new medicine might be accepted on faith, just as was the older folk medicine. However, the medicine show "pitch" appears to be successful partly because the audience's desire is satisfied to have some new faith based on some apparent knowledge. Visual observation provides a reasonably solid sense of knowledge, and "seeing is believing."

Although the 1974 research provided answers to some basic questions concerned with the effectiveness of the medicine showmen, a major question remained still unanswered. We know many low-income Mexicans sought health information through contact with medicine showmen, but not much was known about those low-income Mexicans who did not. Where did these others seek help? Were there any differences in health-related beliefs and orientations between those people who patronized the medicine showmen and those who did not? And if there were differences, how were they related to the patronization of the medicine showmen? The major objective of field research undertaken by Simoni in 1976 was to answer these questions.

Results from the 1976 field research[5] indicated that the key to comprehension of why some low-income Mexicans frequent medicine shows and why others do not, is not simply the identification of the health orientations which exist among the two groups. Rather, the answer is found in the determination of where these people are along a continuum of change from folk-traditional medicine to modern scientific medicine. The 1976 research data suggested a critical perspective of the transition process experienced by low-income people in Mexico, and probably in other developing communities, as they shift from folk-traditional thoughts about health to more modern scientific health orientations.

Nonclients with folk-traditional health orientations deal with health risks for the most part through contact with sources of health care whom they consider to be part of the folk medicine arena (curanderos, herberos, etc.). Many of these same people will be found in contact with scientific sources of health care (physicians, druggists, nurses) when they judge the health risks involved to be sufficient to warrant such action. However, the data indicate that these are not individuals who apparently seek information and experiences in order to learn more about scientific medicine. Rather, clients with folk-traditional health orientations are people who apparently <u>are</u> curious about modern scientific medicine.

The existence of a segment of the low-income population that exhibits modern scientific health orientations and yet patronizes merolicos supports our contention that merolicos are considered to be part of modern scientific medicine. These individuals either currently make definite changes in their health orientations or have already done so. In either case they view medicine showmen as "safe" representatives of modern medicine, as sources of information and further experimentation. Finally, we have a segment of the low-income population which has completed the transition from folk to scientific medicine and has come to realize that medicines offered by the medicine showmen often present low gain, if any gain, propositions.

The 1976 data strengthened the argument to use communication techniques modeled on the medicine show as part of public health programs in Mexico. The data suggested that many low-income Mexicans, some with already changed health orientations, are involved in the transition from folk-traditional medicine to the acceptance of modern scientific medicine. The findings further indicate that these people seek out what they consider to be reliable sources of information who can provide them with both helpful information and experiences about modern scientific medicine. They lack confidence in perceived formal sources of modern medicine and seek a safe liaison.

The two sets of research data from 1974 and 1976 indicated that: 1) merolicos, Mexican medicine showmen, are effective health communicators; and 2) merolicos are viewed by a large segment of low-income Mexicans as representatives of modern scientific medicine from whom

they can learn. Based on these findings, the Mexican National Council of Science and Technology, CONACYT, with the approval of the Mexican National Health Council, decided to finance a pilot project to test the use of merolicos as communicators of public health information. The implementation phase of the project has just been completed. Data for the evaluation phase will be collected in October and November.

The reason why merolicos or Mexican medicine showmen should be discussed is fairly obvious. We believe that ideas developed from research on merolicos should be considered in the development of public health education programs for Mexican American communities. The remainder of our presentation will deal with this question.

We do not want to imply that only one perspective on illness and health is common among all Mexican Americans. However, some generalizations can be drawn which can help us to understand how and why many Mexican Americans seek health care in their communities. First, many Mexican Americans identify with the Mexican culture they left and attempt to copy aspects of that culture to the limits permitted by their new host culture. Most come only for economic reasons. Many return to live in Mexico or constantly go back and forth. Compared to the total number of Mexican Americans who live in the United States, relatively few seek to become naturalized citizens. Many Mexican Americans maintain social and/or emotional attachments to Mexican communities where merolicos exist as a social institution. One reasonable possibility is these people would be receptive to medicine showman types who function as communicators of public health information in Mexican American communities.

Second, we assume that many Mexicans who come to the United States have folk-traditional thoughts about health, and experience a transition to more modern scientific health orientations. During this transitional period, these people would probably seek information which will enable them to learn more about modern scientific medicine, and to seek this information from individuals considered to be "safe" representatives of modern medicine. We have every reason to believe that medicine showman types would be considered "safe."

Finally, we must consider the case of the undocumented illegal Mexicans who live in every Mexican American community in the United States. These individuals, for their own protection, will avoid contact with anyone they view as part of the establishment. If health authorities want to provide health information to illegals, then they must utilize communication channels which will not appear to threaten their status and tenure here in the United States. Again, we believe the medicine show would fit the bill.

Very often Mexican American acceptance of modern scientific medicine has been achieved at the expense of the creation of unnecessary tensions and disruption of community social organization. Solutions which preserve the essential values and autonomy of both the majority

and minority cultures merit greater consideration. The use of paraprofessionals has been suggested and possible obstacles to their integration within formalized health programs have been discussed. These same potential obstacles should be mentioned in the consideration of the use of medicine showman types as public health educators:

1. Medicine showman types would include many quacks, charlatans, hysterical and generally unstable personalities. This problem could be solved by the institution of a careful selection process.

2. Methods used by medicine showmen would be crude, primitive, and often harmful. We believe, based on our experiences in Mexico, that the useful methods could be maintained while potentially harmful methods would be discarded.

3. If medicine showmen are trained, their shows will be less effective. The shows must be left in their "natural state." Our response to this criticism, based on our research in Mexico, is that medicine showmen can be trained without a significant change in how their public views them.

4. The use of medicine showmen will threaten the jobs of professionals who work in the field of public health. Very simply, we feel that emphasis should be placed on the development of quality health communication programs. The effective public health professionals will not be threatened, only those who design unsuccessful programs.

In this paper we have shared with you some ideas as to the feasibility of the utilization of medicine showman types as part of public health education programs in Mexican American communities. Many low-income Mexican Americans, some with already changed health orientations, are involved in the transition from folk-traditional medicine to the acceptance of modern scientific medicine. These people seek what they consider to be reliable sources of information who can provide them with both helpful information and experiences. They lack confidence in scientific medicine and therefore are receptive to what they consider to be safe liaisons. This kind of liaison role is absent from most public health programs in Mexican American communities. The creation of such a role should be considered to improve efforts to help people execute the transition from folk to scientific medicine.

Furthermore, we believe that medicine showmen, trained to deliver public health pitches on such topics as venereal disease, nutrition, family planning, dental care, and general hygiene, can play such a role. Our research suggests that medicine showmen would be accepted in the role of expeditors who could function as interpreters betweer professionals and target Mexican American subcultures, that is as educators and as helpers. They could function as conveyers who transfer knowledge from scientists and physicians to health care consumers,

and as knowledge builders and linkers who could operate as boundary-spanners with a dual orientation toward both scientific soundness and situational usefulness.

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FOOTNOTES

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SESSION III:

Use And Evaluation Of Media In Disseminating Health Information

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SESSION III: USE AND EVALUATION OF MEDIA IN DISSEMINATING HEALTH INFORMATION

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Opening Remarks

Thank you for the invitation to speak to you. The task of this conference is vitally important, not just to Chicanos and health professionals, but to the well-being of the United States. I hope my remarks will make a small contribution to the future growth in this area.

Chicano Media Environment

We cannot talk about the use of media in communicating health information to Chicanos without taking notice of the media environment in which we Chicanos live and work. This environment includes not only the growing print and broadcast Spanish-language media that many advertisers think about when designing campaigns targeted to Chicanos, but also a growing complement of bilingual media, particularly print and video, and an increasing penetration of English-language media. Overall, we find Chicanos using a growing range of print and broadcast media in Spanish, English and bilingual formats. This trend should be considered when evaluating which media to choose to introduce health communication messages.

Spanish Language Media

In 1954, sociologist John Burma predicted the Spanish-language press in the United States would be dead in 15 years. Yet, 15 years later, by 1970, the press was still alive and well and is even more vibrant and vigorous today than it was a decade ago. There are 9 Spanish-language dailies in the United States, some produced along the border for two-way distribution. Growing numbers of weekly and community papers, both commercial and noncommercial, and a heavy supply of imported magazines reach the Chicano audience.

The biggest growth in the past 5 years has been in broadcasting. Over 600 radio stations now air some Spanish programming; 100 of these

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stations broadcast full time in Spanish. There are 20 full time television stations. We project the growth of television into smaller and medium sized markets over the next decade. Spanish radio broadcasting will increase, but some markets will reach their limit.

Movies and records are frequently used by Spanish-speaking Chicanos, but the use is heavily dependent on imported content. Only recently have domestically produced records received the necessary airplay to make them competitive with imports. The domestic movies have not yet grown as fast. Most movies still are dubs and imports.

Spanish-language media offer the best vehicle for some messages because their audience is 100 percent Hispanic (Chicano). Messages can be tailored to the needs and habits of our people. Local newspapers, magazines, television, and radio should be used to present messages in Spanish. Movies and slick magazines, although they have the potential to reach large audiences, are currently not the most effective way to inform your target audience.

Broadcasters are required to air public service announcements (PSA's) and public affairs messages. However, they usually do so infrequently or at times when the audience is smallest. Also, most station personnel generally lack the resources to spend a lot of time and effort on the production of public service announcements. Print media staffs are also small and not geared to produce community-oriented announcements. Therefore, this puts more responsibility on you to design, produce, implement, and evaluate a communication campaign.

English-Language Media

English-language media for many years has ignored Chicanos. Radio, television, films, and newspapers called us the "invisible minority" when we were discovered about 19 years ago, and we were relegated to stereotyped portrayals like bandidos, sexy senoritas, fat mamacitas, or Latin lovers. Now Anglo media grant us higher visibility, although the themes tend to revolve around two categories: Chicanos as problem people who either cause or are beset by problems, or "zoo stories" that occur when reporters come into the barrio during cinco de Mayo, diez y seis de Septiembre, y Diciembre, etc., and take pictures of us in our quaint native costumes. They do not consider us a serious audience. Some daily newspapers have written off the Chicano audience as a low-income nonreading audience that is unattractive to advertisers. Others have taken a more aggressive stance and have pursued potential Chicano readers, particularly in large market share communities.

English-language media are not targeted to the Chicano community and thus are generally less concerned about our needs. But they still have a responsibility to us. They have more resources and larger staffs to aid in production. They also reach a lot of Chicanos and may have higher credibility as an information source than Spanish media. The problem is that most don't realize how important we are

to them and therefore see our needs as being relatively unimportant. Again, you have an opportunity, but you must approach it systematically. First, know what you want to get across and to whom. Then convince the media managers of the importance of your message so they will cooperate and assist you. Once again, local efforts will probably succeed more effectively than national ones, because network TV and magazines are hard to penetrate with public service information.

Chicano media, for lack of a better term, are bilingual or English-language media directed at our community and seen in community newspapers, theatres, public television, regional and national magazines. Most of these media are locally or domestically produced and thus, you have an excellent opportunity to use them for your campaigns. And, the media will grow in popularity as the bilingual and English-language capability of our people increases.

But today audiences are small; so are staffs and budgets. Chicano media are at a developmental stage and you will, again, need to plan and coordinate your efforts carefully.

Chicano Media Use

How do we use the media? A review of the literature which examines patterns of both language and media use elicits a few general statements:

1. Increase in number of bilingual Chicanos. Spanish is still the dominant and preferred language, but bilingualism is growing. The census bureau reports 78 percent of Latinos indicate they speak or understand English, but most of them prefer Spanish as the means of communication. Demographers predict, however, that the portion of the group preferring English over Spanish will experience the sharpest growth over the next decade. Those speaking only Spanish are largely concentrated into 3 predictable groups: recent arrivals, the very young, and the very old. They don't forget Spanish upon learning English.

2. The second point refers to the use of the mass media. Television is the most widely used of the mass media for the American public. This is also the case among the Chicano population. Although programs targeted to the Spanish-speaking groups do exist and have the strong support of Chicanos, there is a drift away from these programs as the population learns more English and becomes more accustomed to English-language television.

   Second, Spanish-language radio is still a strong influence for most Chicanos. One reason why this listening habit has been retained is because there is a preference among bilingual Chicanos for Latino music, found almost exclusively on Spanish radio stations.

3. The third general statement concerns the use of media by low socioeconomic status Chicanos. The use of Spanish-language media has been correlated to socioeconomic status and primary language of the audience, although these data are not definite. Surveys indicate that the sectors of the Chicano community which depend most on Spanish-language media are: 1) those of lowest socioeconomic status; and 2) those with a preference for Spanish as their primary language, such as Chicanos who have recently arrived in the United States or who are living in Mexican neighborhoods or barrios. A study by Williams and Valenzuela shows that those who responded to questions in Spanish used more Spanish-language media then those who answered in English.

4. Point four is about media used by middle income Chicanos. Middle-income Chicanos use a greater variety of media--English, Spanish, and bilingual--when seeking information. They use different media for different purposes. Spanish-language radio is used for background music and some information needs, English-language television for entertainment and news, English-language print media for news and features, and Chicano media for Chicano-related news.

5. Point five is greater marketing efforts are aimed at Chicanos. Different media reach different strata, and different strata may use media differently. The recent upswing in the number and amount of media directed toward Chicanos is not an accident, nor is it directly correlated to the number of Chicanos, or the number of Chicanos interested in entering media careers. Rather, it is a factor of media economics, primarily marketing and advertising. Without going into the causes, suffice to say there are a lot more messages speaking through a lot more voices at Chicanos than there were 10 or even 5 years ago.

   Advertising expenditures were up from $40 million to $70 million between 1972 and 1977; and are probably at $100 million today. These are not just ads for used car lots, furniture stores, or makers of tortillas and chilies, some of what many people would consider the traditional products associated with Chicanos. Big Mac is after the Mexican, so are Colonel Sanders, Miller High Life, and Kool cigarettes. These advertising messages are having an effect and to the extent that such products change the consumption and health habits of Chicanos, they are changing our diet and health.

In planning health communication campaigns, we cannot asume language equals culture. A 1976 Miami study shows a high retention of Spanish among Cuban Americans. But they also eat more often at hamburger and fried chicken takeouts than the overall Miami population. Culture is not always linked to language and we cannot assume that the use of Spanish-language media is a guaranteed way to reach the audience. Particularly heavy new advertisers are fast food outlets, alcoholic

beverages, and tobacco products.

Where does health communication fit into all of this? First, let's start where you are and where Chicanos are. There is a long, if not extensive, supply of literature which evaluates the effectiveness of health communications and other persuasive or intervention media campaigns. We should not assume, just because we are dealing with a segment of the United States population, that findings that have been found to be generally true in other settings would not apply to Chicanos. In fact, we can probably assume that many of these general findings should be applied and tested. Basically, the general findings indicate:

1. The process is one of information from attitude to behavior; but that the jump from attitude to behavioral change is a difficult one to make smoothly.

2. Media's universal effect is one of reinforcement and it is difficult for media campaigns alone to break down longstanding attitudes or behaviors.

3. Media campaigns show more immediate results when linked with interpersonal counseling, but differences between the two sources narrow over time.

4. Complex messages are not as well transmitted by the media, and those information campaigns with the greatest effectiveness suggest an action alternative to the audience. The effectiveness is affected by the type of change desired.

5. Audience predisposition to the topic can affect the effectiveness of the media campaign.

6. Effectiveness varies by differences among socioeconomic status in media use and information-seeking behavior.

7. Appeals that stress the benefits of desired behavior rather than the negative effects of noncompliance tend to be better received.

8. There are multiple measures of effectiveness: awareness, knowledge, attitude, behavior, physical response.

Similarly, you should not ignore the literature that has been developed about the response of Chicanos to information and persuasive campaigns. These data, coupled with the media use characteristics of the audience, can form a useful guideline in the design, implementation, and evaluation of campaigns. Generally, these data show the following:

1. Chicanos do respond to targeted campaigns.

2. Response is higher when the design of the campaigns utilizes regional differences in the language and cultural patterns of the target audience.

3. A greater response is achieved when campaigns are planned based on the types of media used by Chicanos.

4. Media managers are willing to cooperate with health communication professionals, provided that you do much of the work and your manner of presentation is consistent with their format.

5. If people are seeking information on the topic you promote, the response rate will be higher than if the topic is not of primary concern to them at that time.

Now, I'm not an M.D., but I would like to try to prescribe what appear to be some of the elements of a successful campaign. This will be a general prescription, one that can be applied by all who either have a lot or few resources.

1. Needs assessment. Assess the health needs of the target population in general or in terms of how the needs relate to your health specialty. Include an ascertainment of high risk groups, causes of the condition, possible solutions, and available services.

2. A comprehensive plan. In consultation with others, design a comprehensive plan to address the needs. Communications media can play an important role, but probably for awareness and persuasion rather than to solve the problems. The plan should specify the need, target groups to reach, explicit goals, and a plan to evaluate the program's effectiveness.

3. Pretest. This need not be massive, but you should try out and evaluate on a small scale what you plan to do on a larger scale. This will help you refine and design your format.

4. Execute. Carry out the plan. Expect difficulties but do not lose sight of your goals.

5. Evaluate. You can measure change at several levels. You may need precampaign measures of awareness, knowledge, attitudes, behavior, and physical conditions. You should also measure changes over time to see if you have had a long-range effect.

Thank you and good luck with your health communication program.

MEDIA CONSUMPTION HABITS OF MEXICAN AMERICANS

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While much has been written about the media consumption characteristics of blacks,[1-4,8,9,16] very little literature exists on this subject with respect to Mexican Americans, whose size, over 9 million in 1972,[11] makes them the second largest minority group in the United States. The lack of national attention to this ethnic group has largely been the result of their regional concentration in California, Arizona, New Mexico, Colorado, and Texas. However, as their migration has increased and as companies have extended operations into the states near Mexico, interest in the Mexican American market segment has increased.

METHOD

Data for the study reported here were gathered in San Antonio, Texas, an excellent location for such an investigation because this city has the second largest urban concentration of Mexican Americans in the United States. According to the 1970 census (U. S. Bureau of the Census, 1970), 378,157 of the 864,014 residents of the San Antonio Standard Metropolitan Statistical Area (SMSA) speak Spanish.

The universe, defined as the private households with telephones in the San Antonio SMSA, was stratified geographically by ethnicity and by a purchase power index composed of selected socioeconomic characteristics. Within the 18 strata which resulted, 45 clusters were selected based on a probability-proportionate-to-size principle, and within each cluster, streets were selected randomly and households were selected systematically with a random start.

The stratification involved a division of the population into a number of subpopulations (or strata) which did not overlap. A sample was taken from each of the strata.

The city was divided into two census tracts, those in which 95 percent or more of the residents were Anglos and those in which 95 percent or

more of the residents were Mexican Americans (defined as Spanish-speaking, Spanish-surnamed). Each of these strata (nine for Anglos and nine for Mexican Americans) were further subdivided by rough indexes of buying power (specifically, median family income and level of education of the household head). Those were the 18 strata. Thus, one would have three Anglo strata with low buying power index, three Anglo with moderate buying power index, and three Anglo with high buying power index. A similar separation was devised for the Mexican American groups.

The 18 areas were outlined on a map of San Antonio. These areas were further subdivided into 45 clusters which were simply smaller geographical areas which appeared to represent the desired demographic features: either Anglo or Mexican American and of the appropriate buying features. We then used street addresses in these clusters and a criss-cross telephone directory to select persons to call systematically with a random start with n^{th} choices based on population parameters. The numbers skipped between choices varied so that we would get the same proportion in our sample that we found in the universe.

Eighteen strata and 45 clusters were selected because the data fit into that design. More divisions would have made the data too dispersed and hence would have eliminated the geographic representativeness of the data. Experienced bilingual interviewers made at least three attempts by telephone to contact male and female household heads at the addresses chosen in the sample.

Evidence which points to the representativeness and validity of the conclusions reported below is that: 1) considerable similarity exists between the sample and population demographics, as reported by the U.S. Bureau of the Census in Current Population Survey; 2) these results parallel closely the few previous media-related studies of Mexican Americans;[5,6] and 3) these results parallel parts of our earlier research which focused, in large part, on Mexican Americans as respondents.[7,13,14,15]

Our sample included 236 Spanish-speaking, Spanish-surnamed Mexican Americans and 231 Anglo Americans, and was drawn in early December, 1972. In the report of our results, we regard differences between Mexican Americans and Anglos as statistically significant if they reach the 0.05 level of probability or less.

The purpose of our research was to investigate whether the media consumption pattern of the Mexican American market segment is significantly different from that of the larger Anglo population. We were interested in the determination of whether advertisers must make a special effort in media selection and strategy to reach urban Mexican Americans or may effectively rely on conventional Anglo-oriented methods.

FINDINGS

On the question of media availability, these results show that Mexican Americans are just as likely as Anglos to report that they have easy access to a television or radio or to say that they subscribe to a daily newspaper, but Anglos are significantly more likely to subscribe to two newspapers.

Television

No significant difference exists between Mexican Americans and Anglos in the average number of hours they spend each week to watch television. The only variation in frequency of television viewing by days of the week is that Mexican Americans watch television more on Sunday while Anglos watch television more on Monday. The two groups do not significantly differ in their preferences to watch television news in the morning or at noon, but Anglos are considerably more likely to watch the 5 or 6 p.m. news while Mexican Americans are much more likely to watch the news at 10 p.m.

As expected, the Spanish-language television station has a considerably larger audience among Mexican Americans who speak Spanish than among Anglos, but this station's share of the Mexican American audience is smaller than the shares which belong to either of San Antonio's three network-affiliated television stations. One of the affiliated stations has slightly more Anglo than Mexican American viewers (35 percent of the total Anglo viewers compared to 28 percent of the total Mexican American viewers); the second has almost half of the Mexican American viewers but less than 20 percent of the Anglo viewers; while the third has about 45 percent of the Anglo viewers but only 13 percent of the Mexican American viewers.

Local television news personalities are generally equally regarded as favorites by Mexican Americans and Anglos, but among the top 10 such personalities, 2 were more often the favorites of Anglos while a different one was more often the favorite of Mexican Americans. Although an equal number of television news personalities are Mexican Americans, only one was in the top 10 most popular personalities as rated by both ethnic groups.

A contrast of the choices made by respondents of their favorite television programs revealed no significant ethnic differences for law enforcement, suspense, news-related, or game show programs, but Anglos were more likely to prefer family variety and situation comedy programs and Mexican Americans were more likely to prefer movies and "soap operas." Loyalty for viewers for favorite programs was essentially the same for the two ethnic groups. About 90 percent of both groups said they watch their favorite program practically every time it is presented.

Respondents were asked, "If you see something on the national television news, how sure are you that it is true? Would you say that you

are never sure, sure some of the time, sure most of the time, or always sure?" A comparison of responses clearly revealed that the Mexican Americans are more credulous than Anglos about information presented on national news programs.

Radio

While about 85 percent of both Mexican Americans and Anglos say they listen to the radio on the weekends, Mexican Americans are more likely than Anglos (90 percent compared to 82 percent) to listen during the week. Both groups are most likely to listen to radio in the morning but Anglos are more likely to listen in the evening and while they drive to and from work, while Mexican Americans are more likely to listen all day long. Anglos tend to prefer "soft sound" AM and FM stations while Mexican Americans are more likely to prefer "rock and roll" and Spanish-language AM stations. The most important reasons given by Anglos to listen to a favorite radio station are to hear good music and because they enjoy particular disc jockeys while the main reason for station preference among Mexican Americans is to hear Spanish music.

Newspapers

With the exception of neighborhood newspapers, San Antonio has two major newspaper publishers. One publishes weekday morning and afternoon and Saturday and Sunday morning editions, while the other publishes weekday afternoon and Saturday and Sunday morning editions. The total audience of the first publisher's newspapers is 60 percent Anglo and 40 percent Mexican American, while the percentages for the second publisher's newspapers are 43 percent Anglo and 57 percent Mexican American. These data also show that Anglos are much more likely than Mexican Americans to read weekday and Saturday morning newspapers while the reverse is true for weekday afternoon papers.

With the exception of the front page and the comic section, which everyone reads, Mexican Americans are somewhat more likely than Anglos to read the sports page and special advertising supplements, but are less likely than Anglos to read the editorial section. In addition to the higher readership of the advertising supplement by Mexican Americans, they are more than twice as likely than Anglos to believe that advertising supplements contain better buys than those offered in the larger section of the newspaper.

When asked to identify the best source of information about when they want to purchase a new television, Mexican Americans more often said the newspaper, while Anglos more often identified a source which specializes in the provision of consumer information, such as one of the national consumer magazines.

CONCLUSIONS

Although evidence increases that Mexican Americans acculturate toward

the greater acceptance of the values and norms of the larger United States society, the results of this study provide evidence that urban Mexican Americans are sufficiently different from Anglos to require a special advertising effort to reach them effectively. This effort should include considerations such as: 1) judicious choices between alternative television and radio stations and newspapers, because Mexican American station and newspaper preferences do not parallel those of the larger Anglo population; 2) more television advertisements on Sunday and during the 10 p.m. rather than the 5 or 6 p.m. weekday news; 3) more television advertisements during movies and "soap operas"; 4) more funds allocated to weekday radio since Mexican Americans are more likely than Anglos to listen to weekday radio; and 5) more newspaper advertisements near the sports page in the weekday afternoon editions. Finally, an advertisement campaign in these media is probably a highly effective strategy to market products to the Mexican American segment because they are much more likely than Anglos to believe advertisers' messages.

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TELEVISION MESSAGES VERSUS HEALTH COMMUNICATION

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"The purpose of ¡this¿ conference is to identify effective strategies for the utilization of mass, special and interpersonal media in reaching Mexican-Americans and motivating them to take specific positive health actions." I read this over and over, and the more I read it, the more it bothered me. This is a sentence in the first paragraph of a letter sent to me last month by Baylor College of Medicine which invited me to this conference. It bothered me not because I question the motives of this conference, which I feel are sincere and worthwhile, but because it promotes an elitist image which I have shared and from which I try (and urge my students to try) to disentangle ourselves. It has nothing to do with our intentions (although the road to hell is said to be paved with them), but with a prefabricated social role which we as professionals often fall into. It is a role which is augmented by the fact that we live in a technological age which is extremely mass media oriented, and by the accurate conviction that mass media have enormous power of penetration and credibility. Perhaps the sentence would not have disturbed me so much if the word "motivating" had been changed to "educating," for then the meaning of the sentence would not have been, "How do we sell health as a product to Mexican Americans," but, "How can good health and accessibility to health care be presented as an option to the Mexican American population?" This, I assume, is the real intent of this conference and it is part of the issue to which I address myself.

This is the type of question with which the social sciences traditionally occupy themselves. How does any issue become a social issue? How does a society develop a common set of values which are generally accepted? These are primordial questions which thinkers throughout the world and throughout the ages have dealt with. Then there are other applied questions such as, "Is the world headed for famine? Is there freedom of the press? What are the health problems among Mexican Americans? Do they have access to the major medical institutions? What are the social causations of health problems? Of nutrition? Of poverty?" According to Dr. Rose Goldsen of Cornell University:

> The mass media are constantly addressing themselves to these questions explicitly and implicitly. But they are doing so <u>on their own terms and in their own terms</u> ... these terms inhibit serious examination and consideration of these subjects; the burden of messages in the mass media reduces the possibility that the majority of people will think seriously about those subjects; reduces

the chances that they will learn to what degree their individual experiences are socially shared; inhibits learning how their own social system in fact works.[1]

In other words, television messages are not to be confused with education. By their very nature, they preclude education. Paulo Freire calls it "cultural invasion." He says in his very important book Pedagogy of the Oppressed:

> Cultural invasion ... serves the ends of conquest. In this phenomenon, the invaders penetrate the cultural context of another group, in disrespect of the latter's potentialities; they impose their own view of the world upon those they invade and inhibit the creativity of the invaded by curbing their expression.
>
> Whether urbane or harsh, cultural invasion is thus always an act of violence against the persons of the invaded culture, who lose their originality or face the threat of losing it. In cultural invasion the invaders are the authors of, and actors in, the process; those they invade are the objects. The invaders mold; those they invade are molded. The invaders choose; those they invade follow that choice--or are expected to follow it. (1973)

But that should not be so, in the sense of true education. One should be able to make choices in one's own interests; and to make choices one needs not "messages" but information. And not just information since, in a sense, all mass media are informative. Television is especially informative because of its ubiquitousness and its audio-visual nature. It is all-engulfing. It is our new myth-maker and storyteller. In the fabrication and penetration of its myths, it crushes and defeats those myths of our people and yours which gave philosophical meaning to our everyday lives. Television destroys our individually created heroes and replaces them forever with standardized images of corporation-owned characters.

Thus, for true education, one needs information along with the skills necessary to understand and wrestle with the facts. This also means that one must learn how to get access to the facts and, according to Dr. Goldsen, access to the full context necessary to make sense out of these facts. The problem with television is that it is not only a barrier to self-awareness, it is also a desensitizing instrument which allows us to witness a real war in the evening news with the same equanimity with which we view staged violence in a dramatic episode, both of which are religiously and consistently interrupted for a commercial for mouthwash or dish detergent.

To use television to advertise health is really no different from the advertisement of a commercial product in terms of its desired effects. But educators must be aware of a few things related to this. First, they compete against great odds. Most television commercials are antihealth. From the hundreds of sugared cereal commercials aimed at millions of children, to aerosols, to noncreative gizmos and gadgets,

to junk foods, to soda pops, and automobiles which foul the environment, television saturates the total social environment with unbelievably unhealthy messages. To place prohealth messages into the same medium, even if using the same techniques of Madison Avenue, would be like putting a spoonful of water into the ocean. Second, even if it would "work," that is, assuming a few thousand Mexican Americans responded positively to the message, so what? Could that be called success? I would argue that, however noble the cause, we should fight against so-called prosocial engineering, sometimes referred to as "goodthink." If you help program a population to respond to televised or otherwise advertised gimmicks and techniques, no matter how "good" the cause, you strengthen or reinforce its vulnerability to media suggestiveness. And third, to watch television is unhealthy--psychologically, socially, culturally, and probably physically. Teaching health through commercial television is, as we say in Puerto Rico, "Enseñando la moral en calzoncillos."

Well, what do we do? How do we educate our people to "take specific positive health action?" I would first of all suggest that we make them part of the educational process, make them members of those who teach as well as learn--coeducators in the knowledge-sharing enterprise.

There is a lot of folklore as well as folk medicine out there of the type which has kept man alive for thousands and thousands of years. There is folk wisdom out there that should not be lost. Let us make education a complete give and take experience. A few years ago, I conducted a study of folk medicine and spiritism in Spanish Harlem (El Barrio) in New York City with a group of physicians from the department of community medicine of the Mt. Sinai School of Medicine and other health personnel. I concluded my paper with these words:

> Certainly, even a superficial look at the spiritist and his roles in the Puerto Rican community in terms of confessor, advisor, healer, spiritual leader, folk medicine practitioner, and many others, demands that more professional consideration be given to him as a possible candidate for paraprofessional education and training. This will increase the probability of a gradual decrease in the existent gaps, at least between the medical institutions and the local Spanish-speaking low socioeconomic communities.[2]

The notion is rather naive that we hold the keys to knowledge and wisdom and that by way of media techniques we will inject as with a hypodermic a set of "facts" into persons exposed to our message. The effects of messages are not to be found in the people who receive the message. According to Jerry Mander, who wrote Four Arguments for the Elimination of TV (1977), the effects are to be found in "the seventh generation." What he means is that televised messages are not hypodermics. The "message" is shot, not into somebody's buttocks, but into the environment in which we all live and breathe. To

the extent that the message is powerful enough, or is repeated often enough, it penetrates into our cultural space and becomes a part of our social agenda. That is why I mentioned previously that even if a few thousand, or a few hundred thousand Mexican Americans respond positively to a given message, it would mean little if in the long run it does not become a cultural response which cuts across and through generations.

In the second place, I would suggest the necessity to look and step out of our traditional paradigms of education. Many of our Latin American colleagues recognize the need to develop educational techniques that will consider the gamut of social reality. Health awareness cannot be separated from social awareness, a sense of self identity, a sense of one's position in the stratification system, and a need to change the structures that bind one to undignified roles and unfulfilled positions in society. Dr. Goldsen says that Latin American intellectuals, like Paulo Freire,

> ...are looking into the barriers of self-awareness. They are examining power structures. They are trying to pinpoint barriers to acquiring skills, to securing knowledge and utilizing it in forming judgments; barriers to making arguments or evaluating arguments competitively presented by others. Some are trying to innovate pilot programs designed to penetrate these barriers, concentrating mainly on the early years of development--but also on the adult years. Many of these people in research and education are stressing innovations to penetrate these barriers outside the formal educational system.[3]

Thus, part of our educational objective must be to get our people to better understand their social reality, of which health is a part. Barnet and Miller, in Global Reach: The Power of the Multinational Corporations (1974), state on page 175:

> Evangelina Garcia, a specialist in 'social communication' at the Central University of Venezuela and a consultant to McCann-Erickson, J. Walter Thompson, and other U.S.-based global advertising firms, says that the 'most revealing and continually reconfirmed' finding of her studies on advertising is that the marginales (those who are barely hanging on) have 'lost their perception of class differences.' They think that there are, to be sure, rich and poor, she explained, 'but that all have access to the same consumer goods' they hear about on the transistor or see on the TV ... Advertising, she concludes, creates a psychological dependence.

Real education demands that whatever we may think about the importance of "positive health actions," we dare not deceive our people to think think that "all have access to the same consumer goods," or the same access to good health. Rather, we must understand and relay the information that health problems cannot be separated from other socio-

economic problems that plague us as minority group members, or from the ecological and psychological conditions which give rise to so many health conditions. To the extent that we, along with them, develop the tools and the perspectives necessary for this endeavor, we fulfill our role as educators and communicators of information.

FOOTNOTES

1. Rose K. Goldsen, "The Structure and Function of the Mass Media Viewed as a Sociological Institution," published in Spanish in Razon y Fabula, No. 23. Bogota, Columbia: University of the Andes, February 1970.

2. Hector Velez, "Medicine and Folk Medicine in Spanish Harlem," unpublished paper, 1972.

3. Goldsen, op. cit.

WHERE MEXICAN AMERICANS OBTAIN HEALTH INFORMATION

POSTER PRESENTATION:

WILLIAM R. GOMBESKI, JR., M.P.H.
THOMAS J. MOORE, M.S.
Baylor College of Medicine, National Heart and Blood Vessel Research and Demonstration Center, Houston, Texas

MAJOR SOURCE OF HEALTH INFORMATION
IDENTIFIED BY ETHNICITY OF RESPONDENT*

Source of Health Information	White N = 1604 %	Black N = 547 %	Mexican American N = 170 %	TOTAL N = 2,340 %
Doctor	21.8	37.3	35.0	26.4
Newspaper	27.8	9.3	13.5	22.3
Magazine	12.0	7.0	5.0	10.3
Television	16.0	25.0	24.1	18.7
Radio	3.0	3.6	3.5	3.0
All Other Sources; Don't Know	19.4	17.8	18.9	19.3
TOTAL	100.0	100.0	100.0	100.0

MAJOR SOURCE OF HEALTH INFORMATION
IDENTIFIED BY MEXICAN AMERICAN MALES AND FEMALES*

Source Of Health Information	Males N = 64 %	Females N = 102 %
Doctor	35.9	35.3
Newspaper	9.4	16.7
Magazine	4.7	4.9
Television	29.7	21.6
Radio	7.8	1.0
All Other Sources; Don't Know	12.5	20.5
TOTAL	100.0	100.0

MOST ACCURATE SOURCE OF HEALTH INFORMATION
IDENTIFIED BY ETHNICITY OF RESPONDENT*

Most Accurate Source of Health Information	White N=1604 %	Black N=547 %	Mexican American N = 170 %	TOTAL N=2340 %
Doctor	68.1	73.5	64.1	69.1
Newspaper	4.7	2.4	3.5	4.1
Magazine	9.5	4.9	6.5	8.2
Television	5.4	8.6	5.3	6.2
Radio	0.2	0.9	0.0	0.3
All Other Sources; Don't Know	12.7	9.7	20.6	12.1
TOTAL	100.0	100.0	100.0	100.0

MOST ACCURATE SOURCE OF HEALTH INFORMATION IDENTIFIED BY MEXICAN AMERICAN MALES AND FEMALES*

Source of Health Information	Males N = 52 %	Females N = 94 %
Doctor	67.3	78.7
Newspaper	1.9	5.3
Magazine	13.5	4.3
Television	7.7	5.3
Radio	0.0	0.0
All Other Sources; Don't Know	9.6	6.4
TOTAL	100.0	100.0

MAJOR SOURCE OF HEALTH INFORMATION IN THE HOUSTON MEXICAN AMERICAN COMMUNITY IDENTIFIED BY SEX OF RESPONDENT**

Source of Health Information	Male N=502 %	Female N=483 %	Total N=985 %
Medical Personnel	37.6	42.9	40.2
Newspaper	10.6	7.2	8.9
Magazine	8.0	9.7	8.8
Television	20.3	14.9	17.8
Radio	1.8	1.0	1.4
Books	5.8	7.7	6.7
Friends/Family	3.2	5.0	4.1
School	3.6	2.3	2.9
All Other Sources; Don't Know	9.1	9.3	9.2
TOTAL	100.0	100.0	100.0

* To establish a data base upon which to build public health education programs, an in-home community survey was conducted in 1975 to determine the existing knowledge, attitudes, and practices related to cardiovascular disease and its associated risk factors, as well as the media habits of Houston area adults.

** A Community Health Information Program (CHIP) was developed in 1977 using three television spots produced in Spanish. CHIP was designed to determine the relative effectiveness of various mass media and media modalities in achieving desired changes in the health-related knowledge and/or practices related to hypertension control of a randomly selected group of Mexican Americans.

COMMUNICATING FOR GOOD HEALTH: A CHALLENGE

LUNCHEON ADDRESS: MARIO E. RAMIREZ, M.D.
President
Texas Medical Association

Thank you for the invitation to your conference. I bring you greetings from the Texas Medical Association.

The theme which you have discussed is both timely and extremely important. It is a topic which is of great personal interest to me. I sincerely believe that health education--or "Communicating for Good Health"--is one of the greatest challenges which faces our country today. Many national surveys have documented the fact that our people as a whole are ignorant with regard to health. They know very little about basic physiology, about personal hygiene, about good nutrition, about first aid, about simple disease processes, about chronic illnesses and infectious diseases--about birth or death!

For several years I had the privilege to serve on the committee on health care of the poor of the American Medical Association. Our group traveled all over the United States and attempted to study the health problems of the poor in the ghettos of New York City, at the inner-city setting in Cleveland, among the mountain people in Appalachia, at the Indian reservations in Arizona, and in my own area of south Texas, specifically as these problems related to the migrant farm worker. We visited many schools and everywhere we asked, "What are you doing about health education?" The answers were universally the same and uniformly disappointing. Health education was usually delegated to the coach or another teacher on a part-time basis, and health was thought of when it was too wet or too cold to play in the field or to do something else. Few people who were assigned to teach health were really prepared or qualified in this field, and fewer still were really aware of the importance of their assignment.

Four years ago, I was invited to serve on an advisory committee to the Children's Television Workshop, the producers of Sesame Street in New York City. The company endeavored to produce a television series on health education and brought together a panel of educators, health professionals, and communication field experts to advise them. Funding was more than adquate with resources which totaled more than a million dollars for this one project alone. All of us who are interested in health education were excited and elated because for a long time we had felt that television was the ideal medium for effective mass health instruction. We knew that even the most economically deprived homes in this country owned television sets.

The decision was made to use a "variety show" format and to invite

well-known stars from the entertainment world. Subject matter and programming would appeal to all segments of our population. The show, "Feeling Good," was to be televised through public television stations at prime evening time. We went to New York to preview the first programs of the series and all of us were enthusiastic and convinced that this project would be a great success. Such was not the case. The show did not attract the anticipated audience so the format was changed, this time to a "talk show" with Dick Cavett as narrator. The shows which followed were masterfully done. Again the show failed. This failure indicated to me that health education is not a popular topic in America and that people do not want to change their way of life. But the need exists, and something has to be done about it!

Through health education, and with changes in many of our present lifestyles, we can greatly reduce mortality and morbidity from chronic diseases such as heart disease, emphysema, diabetes, many forms of cancer, etc., which are our major killers today. We need to convince people to exercise more; to learn to rest and relax adequately; to eat wisely; and to curtail the use of tobacco, alcohol and drugs. Not only can we alter the course of chronic illnesses, but we can prevent acute illnesses that cripple and are sometimes fatal if people are taught about immunizations, better hygiene, and preventive health. We can control the economics of health care if we teach people about our available health resources and their proper utilization. We can prolong life in many ways and make it a much more pleasant and meaningful experience.

Because of my concerns and interest in health education, I have made this the number one priority during my years as president of the Texas Medical Association. I have named a blue ribbon ad hoc committee to deal with this subject. We have asked them to work with our elementary and high schools, with our colleges and universities, with the state hospital association, the state health department, with people in the communication fields, with voluntary agencies such as the American Cancer Society, and the American Heart Association. The committee will catalogue the health education services and resources which are available in this state, enumerate programs which need to be done, and produce a workable plan for health education for Texas which will be dynamic and effective and which may serve as a prototype for other states.

Your discussions during these past 2 days have been limited to the dissemination of health information to Mexican Americans. This is of special interest to me because of my own ethnic background. My mother was born in Mexico. My father was born in Roma, Texas, and so was his mother and her parents and thus back for six generations. We have lived in south Texas for over 200 years. We have proportionately more Mexican Americans in my county than in any other county in the United States--approximately 95 percent. Our health problems are not very different from those of poor rural communities in other parts of

of the United States. The need for health education looms as a major problem there, too. Solutions must be innovative because of cultural differences, language barriers, and economic realities. Diets which have been printed and prepared for residents of Westchester County in New York are not applicable for the residents of Zapata or Starr counties, Texas.

This conference is of major importance because herein you have had a chance to listen to people who are knowledgeable and experienced in the field of health education and communications. You have had a chance to exchange ideas and to discuss innovations which are essential in order to effectively communicate with our people about health care. You know about our culture and about our economics and because you are a part of the culture, you are best qualified to help formulate plans to achieve the necessary goals. We need to promote health education in the home, at work, in schools, in the hospitals, at the public health clinics, at the doctor's office, and even at the nursing homes. We need the cooperation of people in the fields of communication.

We need to recruit more Mexican Americans into health fields of all types. I am convinced that there exists a very large pool of potential future doctors, nurses, pharmacists, and x-ray and laboratory technicians in the Mexican American community. These students need to be identified, motivated and helped. By help I do not mean that standards need to be lowered or altered. I know that our students can compete on an equal basis and still succeed. I come from one of the poorest communities in the country. Our schools of necessity cannot compete with schools in San Antonio, Houston, or Dallas. Yet, since I came to Starr County 30 years ago, the communities of Roma and Rio Grande City, which have a combined population of 8,000, have produced or will soon have produced 27 physicians. These young people completed premed and medical school at various Texas colleges and universities, and at schools such as Harvard, Yale, Notre Dame, Stanford, Michigan State, and St. Louis. Not one had to interrupt his or her studies because of scholastic inadequacies. Our community has also produced many other health professionals. If Roma and Rio Grande City can do this, certainly other communities can, too.

I thank you again for the privilege of being invited to address you.

MEDIA CRITIQUE SESSION

In the media critique session, conference participants used standardized media critique forms to review and evaluate the effectiveness of print and audiovisual health education and recruitment materials produced by three Houston organizations. The purpose of the session was to make conference participants aware of the guidelines for content and production which should be considered in the design of these materials.

The materials, which were available in Spanish and English, included television PSA's about hypertension, radio PSA's about cancer, and brochures about handling anger.

The media critique forms (one for print materials, one for audiovisuals) provide an objective means to evaluate the effectiveness of print and audiovisual materials. The forms specifically analyze the content, organization, composition (visuals, audio clarity, and format), and the appropriateness of the medium selected to communicate the desired information.

A summary report of the participants' critiques was prepared and returned to the presenting organizations. The print and audiovisual media critique forms are shown in appendix B.

WORKSHOP SESSIONS: RESULTS AND RECOMMENDATIONS

WORKSHOP DESCRIPTION

In the workshop sessions, participants followed the steps of the communications core's health education methodology to design a model health communications campaign based on a case study assignment. The methodology, based on experiences the core gained through evaluating its health education programs, utilizes the major components of the communication process--sender, channel, and receiver--to provide a framework for the planning, development, and evaluation of future health education programs and materials.

The case study dealt with Santa Cruz, a fictional city located in the southwestern United States. Each group was asked to develop a model health communications campaign to inform the Mexican American community about the existence of and services provided by the Santa Cruz Health Maintenance Organization (HMO) for cardiovascular disease. (See appendix A for a copy of the case study and a description of the supplements for the case study.)

Three two-hour workshop sessions were held. A resource panel composed of professionals with a variety of backgrounds (i.e., medical, health education, information specialists, evaluation, psychology, advertising, and marketing) was available during each session to assist each group in the refinement of its model health information campaign. Each group was assigned a recorder who facilitated discussion and documented the group's model campaign and recommendations. (See appendix E for a list of resource panel members and group recorders.)

The assignment of completing a model health information campaign was organized into 10 major tasks and divided by workshop as listed below:

Workshop Session I: Identifying the Problem

1. Define the goals and objectives of the health communication campaign.

2. Define the target population the health communication program intends to reach.

3. Review all data bases by exploring research related to the needs and attitudes of the target audience and by examining all related literature.

Workshop Session II: Health Operations

4. Refine the campaign's goals and objectives based on the review of relevant data bases.

5. Identify the content objectives for the campaign and the available media (i.e., mass, special, interpersonal) that can be used to communicate the health information.

6. Select the specific health information to be disseminated in the campaign.

7. Determine themes and/or appeals to be used for the messages of the campaign.

Workshop Session III: Selecting Communication Channels

8. Select the specific media interventions (i.e., television PSA, radio PSA, brochures, letters) to be used in the campaign.

9. Design a procedure for evaluating the effectiveness of the media interventions (in terms of transmission, reception, storage and action) before, during and after the campaign.

10. Design a schedule which outlines the steps for implementing the campaign.

In addition to designing the model campaign, each group was asked to submit recommendations based on its professional experience and from ideas generated during the workshop to improve the strategies used for the communication of all types of health information to Mexican Americans. The groups were also asked to compose a prioritized list of suggestions concerning the following topics: 1) areas in which further research about health knowledge and practices among Mexican Americans is needed; and 2) techniques for communicating health information to Mexican Americans. Each group presented its model campaign and recommendations at the conference's final session.

RESULTS AND RECOMMENDATIONS

The participants proposed a variety of community interventions to increase the Santa Cruz community's awareness of: 1) the services and programs of the Santa Cruz Health Maintenance Organization for cardiovascular disease; and 2) the factors in one's lifestyle which increase the likelihood of cardiovascular disease. Some of the suggested interventions included a health fair held in cooperation with community organizations to promote the services of the HMO and health measures the public can adopt to prevent cardiovascular disease, like low cholesterol cooking habits; screening programs for cardiovascular disease scheduled at worksites, churches and stores throughout the community; and the creation of a bureau of speakers to give presentations on cardiovascular disease to meetings of church, business, civic, social, or school groups.

Suggestions for Additional Research

1. Obtain demographic characteristics (e.g., reading level, class structure, and average age) of the Mexican American and Spanish-speaking communities.

2. Determine which family members make the health care decisions (e.g., who to consult for help, what type of treatment to use) in Mexican American families.

3. Gain a better understanding of the awareness of the Mexican American community about mental illness, the incidence and risk factors associated with cardiovascular disease, and other health problems.

4. Study the effectiveness of each mass medium (television, radio, and print) and interpersonal contacts (e.g., between doctor and patient) in the communication of health information.

5. Evaluate the role of folk medicine practices of Mexican Americans and their relevance to the utilization of health providers.

6. Analyze the effectiveness of bilingual media presentations in the communication of health information.

7. Determine the knowledge, attitudes, and practices related to health for all Spanish-speaking groups.

Recommendations for Health Educators

1. Develop a model program for the design, implementation, and evaluation of a comprehensive health information/education program aimed at Mexican Americans.
   a. Develop model.
   b. Implement and evaluate model in a community setting.

2. Sustain a distinction between the various Hispanic groups in the design, implementation, and evaluation of health communications programs.

3. Sustain a forum for the exchange of information on practical experiences in health communications with Mexican Americans.

4. Establish a clearinghouse to promote the availability of print and audiovisual health materials in Spanish and maintain a current list of previous and ongoing health education and promotion programs aimed at Mexican Americans.

5. Establish a pool of literature on Mexican American health promotion and education upon which future research and demonstration projects can be based, and distribute a listing of this literature.

6. Involve curanderos and others in folk medicine in the planning stages and implementation of health education programs.

7. Implement an education program to increase the level of awareness of health professionals about the role, content and importance of traditional folk medicine in the lives of the Mexican American community.

8. Utilize themes for health information programs which emphasize the present, rather than future, benefits of the adoption of a healthy lifestyle and encompass the interests of the entire family, rather than the individual.

CONFERENCE EVALUATION

The conference evaluation was conducted in two phases to determine participant's initial and subsequent opinions about the effectiveness of the conference. Phase 1 was administered at the conclusion of the conference and consisted of a four-page questionnaire to determine the participants' opinions of each presentation and their overall comments about the conference. Phase 2 was administered 3 1/2 months after the conference and consisted of a one-page mailed questionnaire to determine the participants' opinions of the usefulness of the conference. (The questionnaires from phases 1 and 2 are found in appendix C.)

The evaluation results for phase 1 are summarized in table 1. The average rating of 4.0 indicates a general agreement exists that the keynote sessions were very useful. Although most of the participants did not rate the concepts covered in the addresses as new (average rating of 2.1), the information was considered to be of better than average applicability (average rating of 3.5).

The participants were nearly unanimous (97.7 percent) in their opinion of the usefulness of the case study. A great majority, 76.6 percent, felt the case study contained sufficient data. Seventy percent said their workshop group interacted well. Table 1 highlights the suggested case study improvements.

The keynote presentations were rated the most useful part of the conference by a majority of the participants (58.5 percent). Research presentations were second (22.9 percent) and workshop sessions third (18.8 percent). When asked to identify the least useful part, 46.2 percent said the research presentations, 43.6 percent the workshop sessions, and 10.2 percent keynote presentations. Table 1 summarizes the participants' recommendations for subsequent conferences and their main reason for attending this conference.

Demographic data shows the participants ranged from 24 to 58 years of age, with modes at 25 and 30. The average age was 36.5 years. Female respondents outnumbered males 56.5 percent to 43.5. Sixty percent were Anglo American, 28.9 percent Mexican American, 6.7 percent black American, and 4.4 percent belonged to "other" ethnic groups.

The evaluation results from phase 2 are listed on table 2. Overall, the respondents (n=58) found the conference to be very beneficial. Eighty-one percent of the respondents said the information presented at the conference was useful. The conference was rated as an above average learning and sharing experience by 43.1 percent and 34.5 percent gave an average rating. Almost 73 percent said they would attend a subsequent conference on the same topic.

The two concepts mentioned most often by the respondents as useful were: increased awareness of the issues involved in health communication with Mexican Americans (19.0 percent); and the importance of preplanning health education campaigns (10.3 percent). Table 2 summarizes the suggestions made by respondents about the topics and structure of subsequent conferences.

TABLE 1.
PHASE I - EVALUATION SUMMARY
(n=47, or 54% of conference participants)

1. Keynote Addresses and Research Presentations — Average Rating (1=poor, 5=excellent)

Keynote Addresses -- Relevance	4.0
Research Presentations -- Newness	2.1
Research Presentations -- Applicability	3.5

2. Case Study

Usefulness:
97.7% Yes, 2.3% No

Sufficient Data:
76.7% Yes, 23.3% No

Group Cooperation:
70.0% Worked together very well

Improvements:
47.7% Reorganize workshop sessions (add more time, use a different style of leadership, focus on fewer issues)
15.9% Make resource panel more available

3. Overall Conference Evaluation

Most Useful Part:
58.5% Keynote Presentations
22.9% Research Presentations
18.8% Workshop Sessions

Least Useful Part:
10.2% Keynote Presentations
46.2% Research Presentations
43.6% Workshop Sessions

Main Reason for Attending Conference:
54.1% Learn more about communicating with Mexican Americans
16.2% Learn more about health communication
13.5% Share own research with others
8.1% Matches job responsibilities
8.1% Other

Recommendations for Subsequent Conferences (Highlights):
20.0% Rearrange case study and workshops
9.1% More consumer participation
9.1% Longer conference
6.9% More time for questions
4.5% More use of Spanish

4. Demographic Profile

Age:
Range: 24 to 58 years
Modes: 25 and 30 years
Average: 36.5 years

Ethnicity:
60.0% Anglo American
28.9% Mexican American
6.7% Black American
4.4% Other ethnic groups

Sex:
56.5% Female
43.5% Male

TABLE 2.
PHASE 2 - EVALUATION SUMMARY
(n=58, or 66.7% of conference participants)

TOPIC	RESPONSE	
1. Usefulness of Information Presented at Conference	81.0%	Yes
	17.2%	No
	1.8%	Not Sure
2. Useful Concepts Identified By Participants (Highlights)	19.0%	Increased awareness of issues involved in health communication with Mexican Americans
	10.3%	Importance of preplanning of health education campaigns
	8.6%	Importance of research on needs and priorities of Mexican Americans
	6.9%	Importance of marketing techniques such as segmenting and targeting
3. Usefulness of Conference as a Learning Experience	43.1%	Above average
	34.5%	Average
	22.4%	Below average
4. Would They Attend Subsequent Conference on Same Topic	72.7%	Yes
	16.4%	No
	10.9%	Maybe
5. Suggested Structure for Subsequent Conferences	19.0%	No case studies
	13.5%	Same conference format
	6.9%	How-to workshops
	6.9%	More time to question speakers
	6.9%	More use of Spanish language
	6.9%	More input from health providers
	5.2%	Description of actual health communication programs

6. Suggested Topics for Subsequent Conferences

- Ways to increase cultural sensitivity of health providers
- How to motivate health providers to study Spanish
- How to use the various media channels to reach the Mexican American
- Reports on health problems and prevention programs specific to Mexican Americans
- Presentations by experts in marketing to minority groups
- How to evaluate community health information and demonstration projects

APPENDICES

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APPENDICES

Appendix A: Community Case Study

Appendix B: Media Critique Forms

Appendix C: Conference Evaluation Questionnaires

Appendix D: Program Planning Committee

Appendix E: Resource Panel Members and Group Recorders

Appendix F: Conference Participant List

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APPENDIX A

COMMUNITY CASE STUDY

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APPENDIX A

COMMUNICATING WITH MEXICAN AMERICANS: POR SU BUENA SALUD

COMMUNITY CASE STUDY

Santa Cruz is one of the fastest growing areas in the Southwest. Spanning nearly 350 square miles and located in the heart of the fertile San Guillermo River Valley, its population has been increasing annually by 45,000 and should pass 2 million by the mid-1980's. Oil, electronics and textiles are its major industries, and the area is well-known for its plentiful fruits and vegetables, particularly its grapefruit which many rate superior to those produced in California or Florida. Only 60 miles from the Gulf of Mexico, the city has become the Nation's second largest port, handling more tonnage than Boston and Seattle combined. An international airport 10 miles west of the downtown area has had a 50 percent increase in traffic in the past 5 years. Total annual wages and salaries in the Santa Cruz area exceed $10 billion, making the city one of the few areas in the country that has continued to prosper during the recession.

Residents of Santa Cruz enjoy its moderate climate (average summer temperature: 74° F; winter: 43° F) and the pace of life the city offers. Three major interstate highways pass through the city providing easy access to the sandy shores of the gulf, the scenic Aldine Mountains which are only 150 miles away, and to Mexico which is only a 6-hour ride. The downtown area has a large number of museums, theaters, and an historical village depicting what life was like in Santa Cruz during the late 1700's. The city also has symphony, ballet and acting companies which perform year-round. The area's 17 universities and colleges provide additional cultural events and attract thousands of students from across the state and the country.

Recreation is a popular pasttime in Santa Cruz. The city's parks system--rated in the country's top 10--contains numerous hike-and-bike trails, tennis courts, pools and athletic fields. Over 10,000 people participate in the softball and soccer leagues sponsored by the city for children as well as adults. Attendance at Santa Cruz's professional baseball, football, basketball, soccer and hockey games has been rising steadily as the population increases and the teams challenge for division titles.

According to 1970 census figures, Mexican Americans constituted 20 percent of the city's population (55 percent Anglo, 24 percent black, 1 percent other). Best estimates predict that, by 1980, this percentage will rise to over 23 percent. The mean age of the Mexican American population has dropped 2.3 years in the last decade and is cur-

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Case study prepared by Thomas J. Moore, Public Affairs Specialist for Health Education, Communications Core, NRDC, Baylor College of Medicine, September 1979.

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rently 7.4 years lower than the mean for the Anglo population. Nearly 90 percent of the Mexican Americans are Catholic. Four members of the 16-member city council, one of the four county commissioners, the assistant city attorney, and the assistant superintendent of the Santa Cruz Independent School District are some of the more prominent public officials who are Mexican American. Each fall, a Santa Cruz Festival is held commemorating the founding of the city by Santa Cruz, a Mexican priest who, in 1684, established a mission around which the town grew.

Santa Cruz has excellent medical care including 43 hospitals and 8 neighborhood health clinics. Seven medical and health professional schools provide training and support staff for the medical facilities. The clinics supply outpatient services ranging from dental care to physical examinations. There is at least one clinic within a 10-mile radius of every Santa Cruz resident. However, many people, especially in the lower income areas, have difficulty getting to the clinics because the city's bus system (the only available mass transportation) is unreliable and does not serve some of the barrios areas.

Despite its impressive facilities, the hospital system has many weaknesses which are common even in smaller communities. The hospitals and clinics both have a shortage of bilingual personnel, making it difficult to discuss a medical problem with the thousands of Mexican Americans who cannot speak English. The communication problem is one of the factors which contributes to a misuse of hospital services. Many people, not just the Mexican American population, are unaware of the procedures that should be followed to handle common medical emergencies. For example, the overcrowded emergency rooms in the inner city are constantly filled with patients in the waiting room who come to be treated for minor ailments that could be handled as easily by the clinics. Therefore, some of the patients with serious injuries do not always receive medical attention as quickly as their injuries require.

A study of the Santa Cruz community reports that many Mexican Americans lack basic knowlege about health. When asked to identify the major cause of death in the country, 30 percent of the Mexican American population gave the correct answer, cardiovascular disease, compared to 56 percent of the Anglo population. The Mexican Americans also showed a much lower understanding of diet factors, including cholesterol intake, which contribute to heart disease. Only 14 percent of the Mexican Americans mentioned high blood pressure as a condition that can cause heart disease.

Beginning in 1980, the city and one of the area's medical schools will work cooperatively to design plans for an extensive system of health maintenance organizations. One of the first steps of this program is to develop a citywide preventive health program for cardiovascular disease (CVD). In making the announcement of the plan for the HMO, Santa Cruz Mayor McAndrews cited many facts connected to the preva-

lence of cardiovascular disease. "Nearly one million people die each year from some form of heart and blood vessel disease. In addition, one in six adults has hypertension (high blood pressure), a condition which, if untreated, can cause heart attack or death. The sad thing is that many of these people, especially the lower income classes, do not realize they are hypertensive." The mayor also mentioned cigarette smoking, obesity, stress and cholesterol as factors which can contribute to cardiovascular disease.

Efforts to establish HMO's in Santa Cruz in the past have been unsuccessful because of the great resistance expressed by the medical community towards the creation of the organizations. Many of the administrators from the inner-city hospitals, whose patient-to-bed ratios have already been falling due to the growth in suburban hospitals, objected to the idea because they feared HMO's as a competing health service which would reduce their income by performing outpatient and laboratory testing services normally done in hospitals. The Santa Cruz Medical Society shared the same financial concern and doubted whether HMO's could perform medical services as well as physicians. Community health organizations, like the American Heart Association and the American Cancer Society, and local businesses involved in improving health, such as health spas and centers for weight reduction and smoking prevention, felt their credibilities were being challenged and their functions were being undermined by the HMO's.

The conflicts in goals and competition for fund raising between the three major medical schools in Santa Cruz also made it difficult for organizers to get all three schools in support of HMO's. Each school also has its own affiliated teaching hopsitals, which like many other hospitals, were skeptical of the need for additional health organizations in Santa Cruz.

One of the keys to the success of the preventive health program for CVD is the effectiveness of the techniques used to publicize the program's existence and services. The program has three major target audiences: Anglos, blacks, and Mexican Americans. San Juanita Sanchez, a board member of the Greater Santa Cruz Hospital District, is in charge of coordinating the campaign to inform the Mexican American community about the program. She has a difficult task ahead not only because of the past opposition by the medical community toward HMO's, but also because only a small number of communication strategies designed to spread health information have been targeted to the needs of Mexican Americans and none has ever covered as broad a topic as she must handle. In addition, few studies have determined the sources that Mexican Americans use for obtaining health information.

Your workshop group, Salud Communicacion, Inc., is one of six companies which Ms. Sanchez has commissioned to design a health communications campaign to inform the Mexican American community about the existence and services provided by the Santa Cruz preventive health programs for CVD. Your group has been given no budgetary restrictions and Ms. Sanchez has informed you that the campaigns will be evaluated on their impact on the target audience, cost-effectiveness and efficient use of available resources. The attached supplements supply additional information.

SUPPLEMENT FOR GROUP 1

Santa Cruz has six television stations, three commercial VHF's (KSTC, KAGR, KWRG), two commercial UHF's (KFJW, KTJM), and public VHF channel KQUR which broadcasts entirely in Spanish two nights per week. Nielson ratings project that nearly one-half of the Mexican American households in Santa Cruz watch KQUR on those evenings. One of the shows is a 1-hour local public affairs program, Esta Noche, in the 7-8 p.m. time slot. Host Manuel Medina discusses a topic of special interest to the Mexican American community. His audience interjects comments and questions the guest expert(s).

The five commercial stations average between 1 and 2 hours of programming for Mexican Americans per week, usually in the early morning hours or on Sunday morning when the television audience is traditionally at its lowest point. Ratings show that two-thirds of the Mexican American audience watch the evening news on KSTC. The commercial stations will broadcast public service announcements in Spanish, but records show that Spanish PSA's are frequently only played in mid-afternoon or the late evening. The stations also have small budgets for producing PSA's for outside organizations. All the VHF news departments have medical reporters and KAGR recently added a reporter who handles Mexican American issues.

Two of Santa Cruz's 19 radio stations broadcast in Spanish. A recent study by one of the stations found that almost 40 percent of the Mexican American population prefers listening to the radio after dinner to watching television.

Santa Cruz has a morning and an evening newspaper. Two Spanish weeklies exist, one of which contains mostly classified advertisements and is distributed free in grocery stores and pharmacies. The Catholic Diocese of Santa Cruz also publishes a weekly newsletter in Spanish.

The Santa Cruz Chamber of Commerce has an affiliated branch called El Alionza de Negocios which consists entirely of Mexican American entrepreneurs. The branch is actively involved in affairs in the Mexican American community and works each year with a large number of volunteer organizations to plan the Santa Cruz Festival.

(Proceed to Task Description)

SUPPLEMENT FOR GROUP 2

Santa Cruz is the home base for three of the Southwest's largest restaurant chains specializing in Mexican American food. Almost 10 percent of the city's Mexican American population either works for one of these restaurants or in a related service industry. Each of the companies has been established for over 20 years and has a solid community image.

Two Spanish-speaking radio stations capture 80 percent of the Mexican American radio audience. A recent study by one of the stations found that almost 40 percent of its audience prefers listening to the radio after dinner rather than watching television. One of the stations has a news and talk show format during the morning and afternoon hours. The other station broadcasts many sports events and does live coverage at many remote locations, including city hall meetings.

Santa Cruz has 14 additional radio stations which broadcast entirely in English. Each of their news departments does a small amount of news coverage of events in the Mexican American community, but they do provide airtime for English translations of Spanish advertisements and PSA's.

The five commercial Santa Cruz TV stations (3 VHF, 2 UHF) provide minimal coverage of Mexican American activities. Public VHF station KQUR provides a live 1-hour public affairs talk show each Sunday evening at 9 p.m. Each of the commercial stations has medical reporters and news reporters to handle Mexican American issues.

Santa Cruz has three daily newspapers which are published in English. Two Spanish weeklies exist which have a combined circulation of about 75 percent of the Mexican American population. These newspapers are composed mainly of classified advertisements and articles of local interest, such as wedding announcements, anniversary parties, and letters to the editors.

The largest textile company has an extensive employee training program designed to improve the quality of life for company employees on and off the job. Ten percent of the Mexican American population works for the company.

Almost one-quarter of the Mexican American teenage schoolchildren belong to an organization, such as a church group, Boy's Club, 4-H, or YWCA. Many of their parents serve as instructors and are members of community and religious groups, too.

(Proceed to Task Description)

SUPPLEMENT FOR GROUP 3

Santa Cruz has six television stations, three commercial VHF's (KSTC, KAGR, KWRG), two commercial UHF's (KFJW, KTJM), and public VHF channel KQUR which broadcasts entirely in Spanish two nights per week. Nielson ratings project that nearly one-half of the Mexican American households in Santa Cruz watch KQUR on those evenings. One of the shows is a 1-hour local public affairs program, Esta Noche, in the 7-8 p.m. time slot. Each program, host Manuel Medina takes on a topic of special interest to the Mexican American community. His audience interjects comments and questions the guest expert(s).

Four of the commercial TV stations provide less than 2 hours per week of programs broadcast in Spanish. Some of the stations' public affairs directors complain that they do not know where to find qualified guests. The fifth commercial station, KAGR, however, does have a daily half-hour program in Spanish and has regular reports during its newscasts on events in the Mexican American community.

Santa Cruz has 14 radio stations, two of which are Spanish-speaking. The 12 English stations do not play public service announcements produced in Spanish, but they will play English translations. News coverage of events in the Mexican American community is limited on these 12 stations.

One of the two Spanish-speaking stations, KAGR, has only been broadcasting for 2 years, but even in that short time, it has gained a solid reputation for providing excellent service to the Mexican American community. For instance, the station carries nationally syndicated news programs which are geared to the Hispanic audience. Local political coverage includes live debates and telephone talk shows. Both the Spanish stations produce numerous local PSA's, often using local sports and community personalities as narrators.

The city health department publishes a biweekly newsletter in both Spanish and English that is distributed free in the neighborhood clinics and hospitals. William Oliver, recently appointed director of health education, has been asked to create new systems for informing the public about the city's health services and the latest medical developments. He has a small staff which devotes much of its time to preparing the newsletter.

Several of the local industries publish in-house monthly newsletters which include human interest articles as well as training and safety features. The editors of these newsletters will often publish material prepared by outside sources provided the information is of general interest to their employees.

(Proceed to Task Description)

SUPPLEMENT FOR GROUP 4

The Santa Cruz Medical Center includes two state universities which have their own television production facilities. Each school produces numerous programs on health for employee and patient training and for the local media. The medical center also publishes a biweekly newsletter which has a circulation of 25,000. The city health department prepares a monthly newsletter which is distributed free in the neighborhood clinics and hospitals. The health department also has a computer listing of all patients who have requested a copy of the newsletter.

Santa Cruz has six television stations, three commercial VHF's (KSTC, KAGR, KWRG), two commercial UHF's (KFJW, KTJM), and public VHF channel KQUR. Only KAGR will broadcast public service announcements in Spanish; however, all the stations will broadcast English translations. KAGR has a daily half-hour public affairs program which airs at 6 a.m. Each of the stations, except KQUR, has a medical reporter and a reporter who specializes in Mexican American affairs.

Two of Santa Cruz's 19 radio stations broadcast in Spanish. A recent study by one of the stations found that almost 40 percent of the Mexican American population prefers listening to the radio after dinner rather than watching television. Both of these stations have small news staffs which concentrate on political reporting.

Santa Cruz has one daily newspaper in Spanish that reaches 70 percent of the Mexican American community. Two other English dailies have a combined circulation of 50 percent. The weekend editions of these papers have medical sections which include articles of national and local interest. The Diocese of Santa Cruz publishes a weekly newspaper which reaches 80 percent of the Catholic Mexican Americans.

The Santa Cruz Chamber of Commerce has a branch called El Alianza de Negocios which consists entirely of Mexican American entrepreneurs. The branch is actively involved with affairs in the Mexican American community and works each year with volunteer organizations to plan the Santa Cruz Festival.

(Proceed to Task Description)

SUPPLEMENT FOR GROUP 5

During each of the last three summers, the University of Santa Cruz has held a series of self-improvement classes available to the general community for a nominal fee. Attendance has nearly doubled each year--this year, over 4,000 people enrolled in at least one class. One of the most popular courses was called "Keep Your Heart Ticking," which attracted over 300 adults. Topics covered in the six 2-hour classes included how the heart functions; the causes of heart disease; the factors in a person's lifestyle which can cause heart disease (e.g., cholesterol intake, stress, smoking, hypertension, and obesity); and how to modify behavior to reduce these factors. Class participants received brochures supplying information on these topics.

Many of the local industries publish in-house monthly newsletters which include human interest articles as well as training and safety features. The editors of these newsletters will often publish material prepared by outside sources provided the information is of general interest to their employees. Some of these companies also produce videotape safety programs.

Santa Cruz has six public television stations, three commercial VHF's (KSTC, KAGR, KWRG), two commercial UHF's (KFJW, KTJM), and public VHF channel KQUR which broadcasts entirely in Spanish two nights per week. Nielson ratings project that nearly one-half of the Mexican American households in Santa Cruz watch KQUR on those evenings.

The five commercial stations average between 1 and 2 hours of programming for Mexican Americans per week, usually in the early morning hours or on Sunday morning when the television audience is traditionally at its lowest point. The stations will broadcast public service announcements in Spanish, but records show that Spanish PSA's are frequently only played in midafternoon or the late evening. All the VHF news departments have medical reporters and KAGR recently added a reporter who handles Mexican American issues.

Two of Santa Cruz's 19 radio stations broadcast in Spanish. A recent study by one of the stations found that almost 40 percent of the Mexican American population prefers listening to the radio after dinner than watching television.

Santa Cruz has a morning and an evening newspaper. Two Spanish weeklies exist, one of which contains mostly classified advertisements and is distributed free in grocery stores and pharmacies. The Catholic Diocese of Santa Cruz and the Chamber of Commerce also publish weekly newsletters in Spanish.

(Proceed to Task Description)

SUPPLEMENT FOR GROUP 6

Nearly one-third of the Santa Cruz Mexican American community belongs to an organization, such as a church, business or social group. Some of the projects undertaken by these groups involve community service work. For example, Job Corps volunteers help teach trades to teenagers and many women's groups do volunteer work in area hospitals and clinics. Over 20 percent of the Mexican American teenagers are members of an organization, including church groups, Boy's Clubs, 4-H, or YWCA's.

A growing number of Mexican Americans are working for oil companies. These companies often have extensive employee training programs designed to improve the quality of life for company employees on and off the job. Firms in other industries also are making bigger commitments to training and safety programs.

The University of Santa Cruz offers a successful program of self-improvement courses to interested citizens for a nominal fee. Classes meet for a 2-month period and range from "Beginning Spanish" to "How to Prepare Crepes for Eight." One of the most popular classes, entitled "Keep Your Heart Ticking," teaches the functions of the heart and the factors in one's lifestyle that can damage the heart. This class has been oversubscribed for 3 years running.

Santa Cruz has six television stations, three commercial VHF's, two commercial UHF's and a public VHF. Less than 1 percent of the broadcast week is devoted to programs geared exclusively to the Mexican American population. All the VHF news departments have medical reporters and one station, KAGR, has a reporter who handles Mexican American issues.

Two of Santa Cruz's 19 radio stations broadcast in Spanish. A recent study by one of the stations found that almost 40 percent of the Mexican American population prefers listening to the radio after dinner than watching television.

Santa Cruz has a morning and an evening newspaper. Two Spanish weeklies exist, one of which contains mostly classified advertisements and is distributed free in grocery stores and pharmacies. The Catholic Diocese of Santa Cruz as well as city health department publishes a biweekly newsletter in English and Spanish.

(Proceed to Task Description)

APPENDIX B

MEDIA CRITIQUE FORMS

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Title _____

Reviewer _____

Date _____

AUDIOVISUAL CRITIQUE FORM
Communications Core

Please rate the following categories as "Good," "Adequate," or "Poor." A "Good" rating denotes that the specific aspect of the production exemplified a high standard which could be considered a model for other productions. An "Adequate" rating denotes an acceptable example which need not be revised, but should not be considered a model for other productions. A "Poor" rating carries with it the necessity for revision. Whenever a category is rated "Poor," please include suggestions concerning its revision in the blank column at the right.

CATEGORIES	RATING	REVISON SUGGESTIONS
A. Selection of Medium (Appropriateness of the medium for the following):		
1. Audience	G A P	
2. Objectives	G A P	
3. Viewing setting	G A P	
4. Instructional tool	G A P	
B. Audio Clarity		
1. Narration		
a. Voice	G A P	
b. Enunciation	G A P	
c. Intonation	G A P	
d. Pace	G A P	
2. Soundtrack		
a. Background	G A P	
b. Sound Effects	G A P	
3. Overall audio quality	G A P	

Developed by National Heart and Blood Vessel Research and Demonstration Center, Communications Core, Baylor College of Medicine, 1980, a grant-supported research project of the National Heart, Lung and Blood Institute, National Institutes of Health, Grant No. 17269. (May be reproduced if credit is given to above mentioned organizations).

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CATEGORIES	RATING	REVISION SUGGESTIONS
C. Content Quality		
1. Organization of Information		
a. Introduction	G A P	
b. Theme	G A P	
c. Logical flow of information	G A P	
d. Information reinforcement	G A P	
e. Conclusion/summary	G A P	
f. Consistent use of theme	G A P	
g. Length	G A P	
h. Clarity of objectives	G A P	
2. Expression		
a. Appropriate vocabulary	G A P	
b. Definition of terms	G A P	
c. Usage	G A P	
d. Grammar	G A P	
e. Use of humor (if applicable)	G A P	
3. Overall Content Quality	G A P	
D. Visual Quality		
1. Composition		
a. Placement of subject	G A P	
b. Horizontal format	G A P	
c. Use of color	G A P	
d. Use of lettering	G A P	
e. Placement of lettering	G A P	
f. Graphic illustration	G A P	
g. Medical illustration	G A P	
h. Lighting	G A P	
i. Focus	G A P	
j. Color contrast	G A P	
k. Editing	G A P	
l. Visual representation of content	G A P	
2. Overall Visual Quality	G A P	
E. Overall Comments on the Effectiveness of the Program		

Title _____

Reviewer _____

Date _____

PRINT MEDIA CRITIQUE FORM
Communications Core

Please rate the following categories as "Good," "Adequate," or "Poor." A "Good" rating denotes that the specific aspect of the production exemplified a high standard which could be considered a model for other productions. An "Adequate" rating denotes an acceptable example which need not be revised, but should not be considered a model for other productions. A "Poor" rating carries with it the necessity for revision. Whenever a category is rated "Poor," please include suggestions concerning its revision in the blank column at the right.

CATEGORIES	RATING	REVISION SUGGESTIONS
A. Selection of Medium (Appropriateness of the medium for the following):		
1. Audience	G A P	
2. Objectives	G A P	
3. Public distribution	G A P	
4. Instructional tool	G A P	
B. Content		
1. Vocabulary relative to target audience	G A P	
2. Definition of terms	G A P	
3. Grammar	G A P	
4. Scientific accuracy	G A P	
5. Use of humor (if applicable)	G A P	
6. Ability to gain/maintain/stimulate interest	G A P	
7. Identification of responsible organization	G A P	
8. Identification of other relevant materials	G A P	

CATEGORY	RATING	REVISION SUGGESTIONS
C. Organization		
1. Introduction	G A P	
2. Theme	G A P	
3. Logical flow of information	G A P	
4. Information reinforcement	G A P	
5. Conclusion/summary	G A P	
6. Consistent use of theme	G A P	
7. Length	G A P	
8. Material format	G A P	
D. Visuals		
1. Appropriateness for audience and objectives	G A P	
2. Graphic illustration	G A P	
3. Medical illustration	G A P	
4. Use of color	G A P	
5. Use of humor (if applicable)	G A P	
6. Visual format	G A P	

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APPENDIX C

CONFERENCE EVALUATION QUESTIONNAIRES

EVALUATION OF THE CONFERENCE ON
COMMUNICATING WITH MEXICAN AMERICANS: POR SU BUENA SALUD
PHASE I

Dear Conference Participant:

In order to assist us in planning future conferences on communications, we would greatly appreciate your frank opinions on the following matters:

Keynote Addresses:

1. How relevant to your needs and expectations were the keynote addresses?

Poor				Excellent
1	2	3	4	5

2. How relevant to your needs and expectations was the keynote address entitled "Socio-Cultural Factors Affecting Communications About Health?"

Poor				Excellent
1	2	3	4	5

What particular points did you find helpful or objectionable in this keynote presentation?

---

3. How relevant to your needs and expectations was the keynote address entitled "Health Values and Perceptions Affecting Communications?"

Poor				Excellent
1	2	3	4	5

What particular points did you find helpful or objectionable in this keynote presentation?

---

4. How relevant to your needs and expectations was the keynote address entitled "Use and Evaluation of Media in Disseminating Health Information?"

Poor				Excellent
1	2	3	4	5

What particular points did you find helpful or objectionable in this keynote presentation?

Research Presentations:

Please give your opinion on the research presentations as to the following criteria:

5. Had you heard the information presented before?

No		Somewhat		Yes
1	2	3	4	5

6. Were the presentations applicable to you in your field?

Not at all		Somewhat		Very
1	2	3	4	5

7. Please specify the presentations which you found most helpful:

Least helpful:

Workshop Sessions:

8. Which workshop group did you attend? _____

9. Was the "case study" approach one useful in integrating the purpose of the conference?

_____ No _____ Yes

10. Did the case study, as presented, contain enough details to enable your group to design a model health communications program? Please comment.

11. Did you feel that your group worked well together on designing the model program? Please comment.

12. What would you have done differently to improve the workshop sessions?

13. How helpful were the resource persons to your workshop sessions?

Overall Evaluation:

14. Which part of the conference did you find most useful? (Check one)

_____ Keynote Presentations

_____ Research Presentations

_____ Workshop Sessions

Which part of the conference did you find least useful? (Check one)

_____ Keynote Presentations

_____ Research Presentations

_____ Workshop Sessions

15. Were there any particular aspects or features of the conference which you found especially helpful?

16. If you had helped to plan this conference, what features would you have recommended to be included or what changes would you have made?

17. How would you rate the following?

Meeting rooms:

Poor				Excellent
1	2	3	4	5

Food at luncheons:

Poor				Excellent
1	2	3	4	5

Housing

Poor				Excellent
1	2	3	4	5

Hospitality

Poor				Excellent
1	2	3	4	5

18. Your AGE _____ SEX _____ ETHNICITY _____

19. Your main reason(s) for attending the conference:

EVALUATION OF THE CONFERENCE ON
COMMUNICATING WITH MEXICAN AMERICANS: POR SU BUENA SALUD
PHASE II

1. Have any of the concepts or information presented at the conference proven to be useful to you? Please explain.

2. As a whole, how useful was the conference to you in terms of a learning and sharing experience?

1	2	3	4	5
Low				High

3. Would you attend a subsequent conference on the same topic?

4. If a subsequent conference is organized, how should it be structured and what type of specific topics should be presented?

5. Please share any other comments that you may have about the conference.

Your cooperation in completing this evaluation is greatly appreciated.

APPENDIX D

PROGRAM PLANNING COMMITTEE

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APPENDIX D

PROGRAM PLANNING COMMITTEE

Annie Collins	Coordinator, Community Development Health Education Branch National Heart, Lung and Blood Institute National Institutes of Health Bethesda, Maryland
E. J. Farge, Ph.D.	Consultant, Communications Core National Heart and Blood Vessel Research and Demonstration Center Assistant Professor, Departments of Community Medicine and Ophthalmology Baylor College of Medicine Houston, Texas
Amelie G. Ramirez, MPH	Assistant Director, Communications Core National Heart and Blood Vessel Research and Demonstration Center Baylor College of Medicine Houston, Texas
Clifford Richmond	Minority Specialist National High Blood Pressure Education Program National Heart, Lung and Blood Institute National Institutes of Health Washington, D.C.
Carlos Vallbona, M.D.	Chief, Control and Demonstration Division National Heart and Blood Vessel Research and Demonstration Center Chairman, Department of Community Medicine Baylor College of Medicine Houston, Texas
Frank J. Weaver	Director, Communications Core National Heart and Blood Vessel Research and Demonstration Center Director, Office of Public Affairs Baylor College of Medicine Houston, Texas

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APPENDIX E

RESOURCE PANEL MEMBERS AND GROUP RECORDERS

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APPENDIX E

RESOURCE PANEL MEMBERS

Workshop Session I

Frank M. Beckles, M.D.	Associate Chief of Psychiatry Director of Psychophysiologic Medicine Service United States Public Health Service Hospital Baltimore, Maryland
Vilma T. Falck, Ph.D.	Associate Professor of Behavioral Sciences School of Public Health The University of Texas Health Science Center at Houston Houston, Texas
Amelie Gutierrez Ramirez, MPH	Assistant Director Communications Core National Heart and Blood Vessel Research and Demonstration Center Baylor College of Medicine Houston, Texas
Armin D. Weinberg, Ph.D.	Director, Secondary and University Education and Continuing Education National Heart and Blood Vessel Research and Demonstration Center Assistant Professor, Departments of Medicine and Community Medicine Baylor College of Medicine Houston, Texas

Workshop Session II

Donald Cassata, Ph.D.	Associate Professor Coordinator of Behavioral Medicine Department of Family Medicine University of North Carolina School of Medicine Chapel Hill, North Carolina

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Michael E. Sammuels, Dr.P.H.	Acting Director Office of Primary Care Bureau of Community Health Services Health, Education, and Welfare Rockville, Maryland
Margie Taylor	Director, Public Information University of New Mexico Medical Center Albuquerque, New Mexico
Carlos Vallbona, M.D.	Chief, Control and Demonstration Division National Heart and Blood Vessel Research and Demonstration Center Chairman, Department of Community Medicine Baylor College of Medicine Houston, Texas

Workshop Session III

E. J. Farge, Ph.D.	Consultant, Communications Core National Heart and Blood Vessel Research and Demonstration Center Assistant Professor, Departments of Community Medicine and Ophthalmology Baylor College of Medicine Houston, Texas
Judith Kautz, Ph.D.	Biostatistician, Design and Analysis Core National Heart and Blood Vessel Research and Demonstration Center Assistant Professor, Department of Medicine Baylor College of Medicine Houston, Texas
William D. Novelli	President Porter, Novelli and Associates Washington, D.C.
Lionel Sosa	President Ed Yarding and Associates San Antonio, Texas
Frank J. Weaver	Director, Communications Core National Heart and Blood Vessel Research and Demonstration Center Baylor College of Medicine Houston, Texas

APPENDIX E

CONFERENCE GROUP RECORDERS

Group 1

Magda Hinojosa-Kramen	Program Officer Chicano Health Policy Development, Inc. San Antonio, Texas

Group 2

Fernando M. Trevino, MPH	Coordinator, Office of Special Programs University of Texas Medical Branch Galveston, Texas

Group 3

Jackie Admire	Coordinator Rural Health Activities Health Education Branch Office of Prevention, Education and Control National Heart, Lung and Blood Institute Bethesda, Maryland

Group 4

Bryant Boutwell, MPH	Communication Specialist Cancer Information Service M. D. Anderson Hospital Houston, Texas

Group 5

Maria Elena A. Flood	Administrator for Academic Affairs Texas Tech University School of Medicine El Paso, Texas

Group 6

Bob Garcia	Health Planner Houston-Galveston Area Council Houston, Texas

APPENDIX F

CONFERENCE PARTICIPANT LIST

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LIST OF CONFERENCE PARTICIPANTS

Communicating With Mexican Americans:
Por Su Buena Salud

September 13-14, 1979
Shamrock Hilton
Houston, Texas

Sponsored by: Baylor College of Medicine
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Research and Demonstration Center

National High Blood Pressure Education Program

National Heart, Lung and Blood Institute, NIH

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